Note 3: All affected Models PA24 and PA24–250 airplanes were equipped at manufacture with P/N 20829–00 main gear side brace studs. All affected Models PA24–260, PA24–400, PA30, and PA39 airplanes were equipped at manufacture with P/N 22512–00 main gear side brace studs. A P/N 95299–00 or P/N 95299–02 stud installed in an applicable Model PA28R–180, PA28R–200, PA28R–201, PA28R–201T, PA32R–300, PA34–200, or PA34–200T airplane may be identified by removing the stud and measuring the shank diameter of the stud. If the shank measures 5/8-inch in diameter, a P/N 78717–02 main gear side brace stud is installed. The FAA is aware of no methods of determining the main gear side brace stud P/N while the stud is installed.

(1) For any main gear side brace stud found cracked, prior to further flight, replace the cracked stud with an FAA-approved serviceable part (part numbers referenced in the table in paragraph (c) of this AD) in accordance with the instructions contained in the Landing Gear section of the applicable maintenance manual, and accomplish one of the following, as applicable:

(i) Reinspect and replace (as necessary) as specified in paragraph (c) of this AD; or

(ii) For the affected Models PA28R–180, PA28R–200, PA28R–201, PA28R–201T, PA32R–300, PA34–200, and PA34–200T airplanes, the P/N 95299–00 or 95299–02 main gear side brace studs are no longer manufactured. A new main gear side brace stud bracket assembly, P/N 95643–06, P/N 95643–07, P/N 95643–08, or P/N 95643–09, as applicable, must be installed if cracks are found as specified in paragraph (a)(1) of this AD. No repetitive inspections will be required by this AD for these affected airplane models when this bracket assembly is installed.

(2) For the affected Models PA28R–180, PA28R–200, PA28R–201, PA28R–201T, PA32R–300, PA34–200, and PA34–200T airplanes, inspect the main gear side brace assembly to ensure that the appropriate number of bushings are installed:

(i) For the 9/16-inch main gear side brace stud, P/N 95299–00 or P/N 95299–02, two bushings must be installed in the bracket assembly.

(ii) For the 5/8-inch main gear side brace stud, P/N 78717–02, one bushing must be installed in the bracket assembly.

(iii) Prior to further flight, replace any bracket assembly where the inappropriate number of bushings are installed.

Note 4: The PA34–200T Illustrated Parts Catalog (Revision dated May 1983, Piper P/N 761 589), Figure 45, Item 52, illustrates this one and two-bushing installation.

(3) For any main gear side brace stud not found cracked, prior to further flight, reinstall the uncracked stud in accordance with the instructions contained in the Landing Gear section of the applicable maintenance manual, and reinspect and replace (as necessary) as specified in paragraph (c) of this AD.

(b) Owners/operators of the affected Models PA28R–180, PA28R–200, PA28R–201, PA28R–201T, PA32R–300, PA34–200, and PA34–200T airplanes may have a new main gear side brace bracket assembly, P/N 95643–06, P/N 95643–07, P/N 95643–08, or P/N 95643–09, as applicable, installed at any time to terminate the inspection requirement of this AD.

(c) Reinspect both the left and right main gear side brace studs, using Type I (fluorescent) liquid penetrant or magnetic particle inspection methods. Inspections must be accomplished by a facility approved by the FAA to accomplish the applicable inspection method. Replace any cracked stud or reinstall any uncracked stud as specified in paragraphs (a)(1) and (a)(3) of this AD, respectively:

Part No. installed	TIS inspection interval	Model airplanes installed on
20829–00	1,000 hours	PA24 and PA24–250.
22512–00	1,000 hours	PA24–260, PA24–400, PA30, and PA39.
95299–00 or 95299–02.	500 hours	PA28R–180, PA28R–200, PA28R–201, PA28R–201T, PA32R–300, PA34–200, and PA34–200T.

Note 5: Accomplishing the actions of this AD does not affect the requirements of AD 77–13–21, Amendment 39–3093. The tolerance inspection requirements of that AD still apply for Piper PA24, PA30, and PA39 series airplanes.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

(e) An alternative method of compliance or adjustment of the initial or repetitive compliance times that provides an equivalent level of safety may be approved by the Manager, Atlanta Aircraft Certification Office (ACO), Campus Building, 1701 Columbia Avenue, Suite 2–160, College Park, Georgia 30337–2748. The request shall be forwarded through an appropriate FAA Maintenance Inspector, who may add comments and then send it to the Manager, Atlanta ACO.

Note 6: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Atlanta ACO.

(f) Information related to this AD may be inspected at the FAA, Central Region, Office of the Assistant Chief Counsel, Room 1558, 601 E. 12th Street, Kansas City, Missouri.

(g) This amendment (39–9386) becomes effective on November 17, 1995.

Issued in Kansas City, Missouri, on September 28, 1995.

John R. Colomy,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 95–24713 Filed 10–4–95; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 1

[T.D. 8606]

RIN 1545–AR23

Definition of Qualified Electric Vehicle, and Recapture Rules for Qualified Electric Vehicles, Qualified Clean-fuel Vehicle Property, and Qualified Clean-fuel Vehicle Refueling Property; Correction

AGENCY: Internal Revenue Service, Treasury.

ACTION: Correction to final regulations.

SUMMARY: This document contains a correction to final regulations, Treasury Decision 8606, which was published in the Federal Register on Thursday, August 3, 1995 (60 FR 39649). The final regulations are on the definition of a qualified electric vehicle, the recapture of any credit allowable for a qualified electric vehicle, and the recapture of any deduction allowable for qualified clean-fuel vehicle refueling property.

EFFECTIVE DATE: August 3, 1995.

FOR FURTHER INFORMATION CONTACT: Joanne E. Johnson at (202) 622–3110 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations that are the subject of this correction are under sections 30 and 179A of the Internal Revenue Code.

Need for Correction

As published, T.D. 8606 contains an error which may prove to be misleading and is in need of clarification.

Correction of Publication

Accordingly, the publication of the final regulation (T.D. 8606), which was the subject of FR Doc. 95–19028, is corrected as follows:

On page 39649, column 1, in the heading, the language ''RIN 1545–AR64'' is corrected to read ''RIN 1545–AR23''.

Cynthia E. Grigsby,

Chief, Regulations Unit, Assistant Chief Counsel (Corporate).

[FR Doc. 95–24781 Filed 10–4–95; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD 6010.8–R]

RIN 0720–AA21

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Program; Uniform HMO Benefit; Special Health Care Delivery Programs

AGENCY: Office of the Secretary, DOD.

ACTION: Final rule.

SUMMARY: This final rule establishes requirements and procedures for implementation of the TRICARE Program, the purpose of which is to implement a comprehensive managed health care delivery system composed of military medical treatment facilities and CHAMPUS. Principal components of the final rule include: establishment of a comprehensive enrollment system; creation of a triple option benefit, including a Uniform HMO Benefit required by law; a series of initiatives to coordinate care between military and civilian delivery systems, including Resource Sharing Agreements, Health Care Finders, PRIMUS and NAVCARE Clinics, and new prescription pharmacy services; and a consolidated schedule of charges, incorporating steps to reduce differences in charges between military and civilian services. This final rule also includes provisions establishing a special civilian provider program authority for active duty family members overseas. The TRICARE Program is a major reform of the MHSS that will improve services to beneficiaries while helping to contain costs.

EFFECTIVE DATE: November 1, 1995.

ADDRESSES: Office of the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), Program Development Branch, Aurora, CO 80045–6900.

FOR FURTHER INFORMATION CONTACT: Steve Lillie, Office of the Assistant Secretary of Defense (Health Affairs), telephone (703) 695–3350.

Questions regarding payment of specific claims under the CHAMPUS allowable charge method should be addressed to the appropriate CHAMPUS contractor.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

A. Overview of the TRICARE Program

The medical mission of the Department of Defense is to provide and maintain readiness to provide medical services and support to the armed forces during military operations, and to provide medical services and support to members of the armed forces, their family members, and others entitled to DoD medical care.

Under the current Military Health Services System (MHSS), all care for active duty members is provided or arranged by military medical treatment facilities (MTFs). CHAMPUS-eligible beneficiaries may receive care in the direct care system (that is, care provided in military hospitals or clinics) on a space-available basis, or seek care from civilian health care providers; the government shares in the cost of such civilian care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Medicare eligible military beneficiaries also are eligible for care in the direct care system on a space-available basis, and may be reimbursed for civilian care under the Medicare program. The majority of care for military beneficiaries is provided within catchment areas of MTFs, a catchment area being roughly defined as the area within a 40-mile radius around an MTF.

Recently DoD has embarked on a new program, called TRICARE, which will improve the quality, cost, and accessibility of services for its beneficiaries. Because of the size and complexity of the MHSS, TRICARE implementation is being phased in over a period of several years. The principal mechanisms for the implementation of TRICARE are the designation of the commanders of selected MTFs as Lead Agents for 12 TRICARE regions across the country, operational enhancements to the MHSS, and the procurement of managed care support contracts for the provision of civilian health care services within those regions.

Sound management of the MHSS requires a great degree of coordination between the direct care system and CHAMPUS-funded civilian care. The TRICARE Program recognizes that ''step one'' of any process aimed at improving management is to identify the beneficiaries for whom the health program is responsible. Indeed, the dominant feature in some private sector health plans, enrollment of beneficiaries in their respective health care plans, is an essential element. This final rule moves toward establishment of a basic structure of health care enrollment for the MHSS. Under this structure, all health care beneficiaries become participants in TRICARE and classified into one of four categories:

1. Active duty members, all of whom are automatically enrolled in TRICARE Prime, an HMO-type option;
2. TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;
3. TRICARE Standard participants, which includes all CHAMPUS-eligible beneficiaries who do not enroll in TRICARE Prime; or
4. Medicare-eligible beneficiaries and other non-CHAMPUS-eligible DoD beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE.

Eventually, we anticipate that there will be a fifth category: participants in other managed care programs affiliated with TRICARE. However, no such affiliations have yet been made.

The second major feature of the TRICARE Program will be the establishment of a triple option benefit. CHAMPUS-eligible beneficiaries will be offered three options: They may (1) enroll to receive health care in an HMO-type program called ''TRICARE Prime;'' (2) use the civilian preferred provider network on a case-by-case basis, under ''TRICARE Extra;'' or (3) choose to receive care from non-network providers and have the services reimbursed under ''TRICARE Standard.'' (TRICARE Standard is the same as standard CHAMPUS.) CHAMPUS-eligible enrollees in Prime will obtain most of their care within the network, and pay substantially reduced CHAMPUS cost shares when they receive care from civilian network providers. Enrollees in Prime will retain freedom to utilize non-network civilian providers, but they will have to pay cost sharing considerably higher than under TRICARE Standard if they do so. Beneficiaries who choose not to enroll in TRICARE Prime will preserve their freedom of choice of provider for the most part by remaining in TRICARE Standard. These beneficiaries will face standard CHAMPUS cost sharing requirements, except that their coinsurance percentage will be lower when they opt to use the preferred provider network under TRICARE Extra. All beneficiaries continue to be eligible to receive care in MTFs, but active duty family members who enroll in TRICARE Prime will have priority over other beneficiaries.

A third major feature of the TRICARE program is a series of initiatives, affecting all beneficiary categories, designed to coordinate care between military and civilian health care systems. Among these is a program of resource sharing agreements, under which a Managed Care Support contractor provides personnel and other

resources to an MTF in order to increase the availability of services. It is our expectation that the Partnership Program, an existing mechanism for increasing the availability of services in MTFs, will be phased out as TRICARE managed care support contracts are implemented. Another TRICARE initiative is establishment of Health Care Finders, which facilitate referrals to appropriate services in the MTF or civilian provider network. In addition, integrated quality and utilization management services for military and civilian sector providers will be insituted. Still another initiative is establishment of special pharmacy programs for areas affected by base realignment and closure actions. These pharmacy programs will include special eligibility for some Medicare-eligible beneficiaries. TRICARE also will feature TRICARE Outpatient Clinics, which will be direct care system resources serving as primary care managers and providing related services. (This final rule also provides a transitional authority for continued operation of PRIMUS and NAVCARE Clinics, which are dedicated contractor-owned and operated clinics, until TRICARE is implemented.) These initiatives will have a major impact on military health care delivery systems, improving services for all beneficiary categories.

The fourth major component of TRICARE is the implementation of a consolidated schedule of charges, incorporating steps to reduce differences in charges between military and civilian services. In general, the TRICARE Program reduces beneficiaries' out-of-pocket costs for civilian sector care. For example, the current CHAMPUS cost sharing requirements for outpatient care for active duty family members include a deductible of $150 per person or $300 per family ($50/$100 for family members of active duty sponsors in pay grades E–4 and below) and a copayment of 20 percent of the allowable cost of the services.

Under TRICARE Prime, which incorporates the ''Uniform HMO Benefit,'' these cost sharing requirements will be replaced, for CHAMPUS beneficiaries who enroll, by a standard charge for most civilian provider network outpatient visits of $12.00 per visit, or $6.00 per visit for family members of E–4 and below sponsors. For CHAMPUS-eligible retirees, their family members and survivors, the current deductible of $150 per person or $300 per family and 25 percent cost sharing for outpatient services will also be replaced by a standard charge, which is likewise $12.00 for most outpatient visits. Retirees, their family members and survivors will also be charged a $230/$460 annual individual/family enrollment fee. Active duty members will face no cost sharing under TRICARE Prime.

Beneficiaries who are not enrolled in TRICARE Prime will also have significant opportunities to reduce expected out-of-pocket costs under CHAMPUS. These opportunities include the new special pharmacy programs, and access to network providers and to TRICARE Outpatient Clinics, on a space-available basis.

One design consideration for TRICARE is the mobile nature of our beneficiary population. Some features of TRICARE, such as the uniformity of the benefit and the consistency of program rules across the country, are crafted with this factor in mind. In the future, we hope to increase the ''portability'' of the TRICARE benefit, by making TRICARE more accessible to beneficiaries who have multiple residences, have family members in several locations, and so forth.

With respect to military hospitals, in the future consideration will be given to establishment of nominal per-visit fees, for some or all retirees, their family members, and survivors, and for some or all types of services for those beneficiaries. Fees would be considered to help control demand for MTF care, to free up capacity and reduce waiting times, and lower the costs of health care.

A user fee can be structured in many different ways, for example, exempting lower income segments of the covered population. Most importantly, the motivation for a fee is to encourage the more efficient use of health care services. When this issue is considered for possible implementation in fiscal year 1988, if the Department decides to establish a nominal fee for some or all outpatient services provided to some or all retirees, their family members, and survivors, a proposed rule will then be issued for public comment.

The TRICARE Program is a major reform of the MHSS—one that will accomplish the transition to a comprehensive managed health care system that will help to achieve DOD's medical mission into the next century.

B. Public Comments

The proposed rule was published in the Federal Register on February 8, 1995. We received 17 comment letters. We thank those who provided comments; specific matters raised by commenters are summarized below in the appropriate sections of the preamble.

II. Provisions of the Rule Regarding the Tricare Program

These regulatory changes are being published as an amendment to 32 CFR Part 199 because the operating details of CHAMPUS will be altered significantly. Our regulatory approach is to leave the existing CHAMPUS rules largely intact and to create new sections 199.17 and 199.18 to describe the TRICARE Program and the uniform HMO benefit. The major provisions of new section 199.17 regarding the TRICARE Program are summarized below. A summary of the relevant proposed rule provision is presented, followed by an analysis of major public comments, and by a summary of the final rule provisions.

A. Establishment of the TRICARE Program (Section 199.17(a))

1. Provisions of Proposed Rule

This paragraph introduces the TRICARE Program, and describes its purpose, statutory authority, and scope. It is explained that certain usual CHAMPUS and MHSS rules do not apply under the TRICARE Program, and that implementation of the Program occurs in a specific geographic area, such as a local catchment area or a region. Public notice of initiation of a Program will include a notice published in the Federal Register.

With respect to statutory authority, major statutory provisions are title 10, U.S.C. sections 1099 (which calls for health care enrollment system), 1097 (which authorizes alternative contracts for health care delivery and financing), and 1096 (which allows for resource sharing agreements). Significantly, the National Defense Authorization Act for Fiscal Year 1995 amended section 1097 to authorize the Secretary of Defense to provide for the coordination of health care services provided pursuant to any contract or agreement with a civilian managed care contractor with those services provided in MTFs. This amendment set the stage for many features of TRICARE, including initiatives to improve coordination between military and civilian health care delivery components and the consolidated schedule of beneficiary charges.

2. Analysis of Major Public Comments

Several commenters objected to the concept that all beneficiaries were ''enrolled,'' and classified into one of five enrollment categories; they suggest that the only true enrollment is in TRICARE Prime.

One commenter questioned implementation of TRICARE in Washington and Oregon effective March 1, 1995, in advance of publication of this final rule.

One commenter suggested that initiation of TRICARE in an area be widely announced, including advance publication in the Federal Register to inform providers how to join preferred provider networks, mailed notice to current providers, and notifications to national associations representing providers. The commenter also suggested that it is inappropriate for DoD to have made decisions on how and in what order TRICARE is to be implemented nationally, in advance of final rule promulgation.

Response. We acknowledge the confusion that arose as a result of some of the explanation in the preamble to the proposed rule. The commenters correctly point out that the only TRICARE option which requires an affirmative ''enrollment'' action is TRICARE Prime. Our intent was to emphasize the all-encompassing nature of TRICARE, and the fact that care for all MHSS beneficiaries will be affected by the advent of TRICARE; in a very real sense, all peacetime care provided or paid for by DoD will become part of TRICARE.

Regarding the implementation of TRICARE in Washington and Oregon on March 1, 1995, prior to promulgation of this final rule, we point out that the program in Washington and Oregon is being implemented under a special demonstration authority (10 U.S.C. 1092) in advance of the promulgation of this rule. If features of the program in Washington and Oregon conflict with the provisions of this final rule, they will be revised after the rule becomes effective.

Regarding notifications to providers about the initiation of TRICARE, we believe that the competitive procurements being conducted for regional managed care support contracts provide ample opportunity for providers to become aware of and involved in the program. We publish advance notices in the Commerce Business Daily, issue formal requests for proposals, and publicize and conduct bidders conferences, in order to inform interested parties as fully as possible.

On the point of DoD making decisions about TRICARE implementation strategies in advance of final rule publication, the promulgation of this rule is entirely separate from operational decisions about the phasing of program implementation. The basic nature of our approach to implementing TRICARE managed care support contracts was directed by Congress, and we reported to Congress in December 1993 on our plan for implementing the program region by region, achieving nationwide coverage in 1997.

3. Provisions of the Final Rule

The final rule clarifies that, while all beneficiaries participate in TRICARE, only the HMO-like option, TRICARE Prime, requires an action on the part of the beneficiary to enroll.

B. Triple Option (Section 199.17(b))

1. Provisions of Proposed Rule

This paragraph presents an overview of the triple option feature of the TRICARE Program. Most beneficiaries are offered enrollment in the TRICARE Prime Plan, or ''Prime.'' They are free to choose to enroll to obtain the benefits of Prime, or not to enroll and remain in the TRICARE Standard Plan, or ''Standard,'' with the option of using the preferred provider network under the TRICARE Extra Plan, or ''Extra.'' When the TRICARE Program is implemented in an area, active duty members will be enrolled automatically in Prime.

2. Analysis of Major Public Comments

None.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

C. Eligibility for Enrollment in Prime (Section 199.17(c))

1. Provisions of Proposed Rule

This paragraph describes who may enroll in the Program. All active duty members are automatically enrolled in Prime; all CHAMPUS-eligible beneficiaries who live in areas covered by TRICARE Prime are eligible to enroll. Since it is likely that priorities for enrollment will be necessary owing to limited availability of Prime, the order of priority for enrollment will be as follows: first priority will be active duty members; second priority will be active duty family members; and third priority will be CHAMPUS-eligible retirees, family members of retirees, and survivors. At this time, TRICARE Prime does not offer enrollment to non-CHAMPUS-eligible beneficiaries.

2. Analysis of Major Public Comments

Several commenters objected to the exclusion of Medicare-eligible military beneficiaries from enrollment eligibility, and questioned the legal basis for such exclusion.

One commenter suggested that enrollment priorities be set nationally rather than locally, with local authority to follow the enrollment priority system only if all eligible beneficiaries cannot be enrolled.

One commenter raised the issue of a CHAMPUS beneficiary with Worker's Compensation coverage related to civilian government employment, receiving care from military providers, asking what effect TRICARE would have on this circumstance.

Response. Regarding the exclusion of Medicare beneficiaries, this is not the Department's preferred position. However, we are unable to offer enrollment to this group without reimbursement from the Medicare trust funds, which would require a statutory revision. Were we to include Medicare-eligible beneficiaries under TRICARE Prime, we would be unable to comply with the cost requirement of section 731 of the National Defense Authorization Act for Fiscal Year 1994. That section requires that the ''Uniform HMO Benefit,'' mandated for TRICARE Prime, must not increase DoD costs. Under law, civilian sector care provided to almost all Medicare beneficiaries is at no expense to DoD because they are not covered by CHAMPUS. TRICARE Prime, however, includes comprehensive civilian sector coverage. Were this to be provided at DoD expense, the additional costs to DoD would be considerable. There is no feasible way to restructure TRICARE Prime to accommodate those costs under the statutory cost neutrality requirement or under current budgetary realities.

With respect to DoD's legal authority to exclude Medicare-eligible beneficiaries from TRICARE Prime, the legal authority for TRICARE Prime, 10 U.S.C. 1097, allows DoD to establish health care plans covering selected health care services or selected beneficiaries. For the reasons explained above, the TRICARE Prime plan adopts the same exclusion of most Medicare beneficiaries as is required by law for CHAMPUS (10 U.S.C. 1086(d)), on which the civilian sector component of TRICARE Prime is based.

Regarding the primacy of national priorities for enrollment, we agree, and reaffirm that the statutory priorities for access to space-available care in MTFs will be used as the national priorities for enrollment; if priorities are needed at the local level owing to limited availability of enrollment during the phase-in of TRICARE, then the statutory priorities will be followed. The only additional prioritizing that is authorized is that, during a phase-in process, priority may be given to family members of members in lower pay grades. Eventually, however, in locations where Prime is offered, all CHAMPUS-eligible

beneficiaries who wish to enroll will be accommodated.

Regarding the effect of TRICARE on beneficiaries with Worker's Compensation coverage, the answer is that we anticipate little change: under TRICARE, MTFs will continue to have authority to bill Worker's Compensation programs and similar parties, and health care from military providers will continue to be subject to availability.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

D. Health Benefits Under Prime (Section 199.17(d))

1. Provisions of Proposed Rule

This paragraph states that the benefits established for the Uniform HMO Benefit option (see section 199.18, Uniform HMO Benefit option) are applicable to CHAMPUS-eligible enrollees in TRICARE Prime.

Under TRICARE, all enrollees in Prime and all beneficiaries who do not enroll remain eligible for care in MTFs. Active duty family members who enroll in TRICARE Prime would be given priority for MTF access over non-enrollees; priorities for other categories of beneficiary would, under the proposed rule, be unaffected by their enrollment. Regarding civilian sector care, active duty member care will continue to be arranged as needed and paid for through the supplemental care program.

2. Analysis of Major Public Comments

Several commenters recommended that preference for MTF care be given to all TRICARE Prime enrollees over all nonenrollees.

Response. We agree that granting preference to MTFs based on enrollment in TRICARE Prime would be an incentive to enroll. In the case of active duty family members, this preference is being granted. However, other considerations must be taken into account when granting such preference for retirees. In particular, because Medicare beneficiaries are not eligible for enrollment in TRICARE Prime, granting such preference would necessarily limit access to MTFs and increase out-of-pocket costs for this large group of DoD beneficiaries. Several options are under consideration to ensure fair and equitable treatment of Medicare-eligible retirees under TRICARE Prime, and we will revisit the issue of access priority as we have more information about these options. In the meantime, we believe that the appropriate course of action is not to base retiree preference for MTFs on enrollment in TRICARE Prime.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

E. Health Benefits Under Extra (Section 199.17(e))

1. Provisions of Proposed Rule

This paragraph describes the availability of the civilian preferred provider network under Extra. When Extra is used, CHAMPUS cost sharing requirements will be reduced. (See Table 2 following the preamble for a comparison of TRICARE Standard, TRICARE Extra, and TRICARE Prime cost sharing requirements.)

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

F. Health Benefits Under Standard (Section 199.17(f))

1. Provisions of Proposed Rule

This paragraph describes health benefits for beneficiaries who opt to remain in Standard. Broadly, participants in standard maintain their freedom of choice of civilian provider under CHAMPUS (subject to nonavailability statement requirements), and face standard CHAMPUS cost sharing requirements, except when they take advantage of the preferred provider network under Extra. The CHAMPUS benefit package applies to Standard participants.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

G. Coordination with Other Health Care Programs (Section 199.17(g))

1. Provisions of Proposed Rule

This paragraph of the proposed rule provided that, for beneficiaries enrolled in managed health care programs not operated by DoD, DoD may establish a contract or agreement with the other managed health care programs for the purpose of coordinating beneficiary entitlements under the other programs and the MHSS. This potentially includes any private sector health maintenance organization (HMO) or competitive medical plan, and any Medicare HMO. Any contract or agreement entered into under this paragraph may integrate health care benefits, delivery, financing, and administrative features of the other managed care plan with some or all of the features of the TRICARE Program. This paragraph is based on 10 U.S.C. section 1097(d), as amended by section 714 of the National Defense Authorization Act for Fiscal Year 1995.

2. Analysis of Major Public Comments

One commenter asked whether this section applied only to managed care plans, or to any medical plan.

Response. To clarify, the section applies only to managed care plans, such as health maintenance organizations. The intent of the provision is to enable MTFs to become participating providers in the networks established by such private plans, or to make other coordinating arrangements, so that military beneficiaries who are enrolled in the private plans may utilize the services of the MTF as part of their managed care enrollment.

The Health Care Financing Administration (HCFA) expressed concerns about the expressed DoD intent to include arrangements with Medicare HMOs under this provision. Further discussions between DoD and the Department of Health and Human Services will be necessary before we complete action on this proposed regulatory provision.

3. Provisions of the Final Rule

The final rule does not include provisions relating to coordination with other health plans. Action is reserved, pending further development.

H. Resource Sharing Agreements (Section 199.17(h))

1. Provisions of Proposed Rule

This paragraph provides that MTFs may establish resource sharing agreements with the applicable managed care support contractors for the purpose of providing for the sharing of resources between the two parties. Internal and external resource sharing agreements are authorized. Under internal resource sharing agreements, beneficiary cost sharing requirements are the same as in MTFs. Under internal or external resource sharing agreements, an MTF commander may authorize provision of services pursuant to the agreement to Medicare-eligible beneficiaries, if this will promote the most cost-effective provision of services under the TRICARE Program.

2. Analysis of Major Public Comments

One commenter suggested that the final rule specify how resource sharing agreements will be established, how providers will be selected, which providers would qualify for resource sharing, and how internal disputes among practitioners would be resolved.

Response. We note that that resource sharing takes place in the context of regional managed care support contracts, established in support of TRICARE. These competitively procured contracts will be the vehicle for selection of providers participating in resource sharing programs, and disputes would be resolved through the contract mechanisms. Any services offered in MTFs or covered by CHAMPUS could, in concept, be subject to resource sharing; hence any CHAMPUS authorized provider category potentially could be part of the program if desired by the local military medical authorities.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except for a clarification of the circumstances under which services provided to Medicare beneficiaries are potentially reimbursable by Medicare: Medicare could pay civilian hospital charges in an external resource sharing circumstance.

I. Health Care Finder (Section 199.17(i))

1. Provisions of Proposed Rule

This paragraph establishes procedures for the Health Care Finder, an administrative office that assists beneficiaries in being referred to appropriate health care providers, especially the MTF and civilian network providers. Health Care Finder services are available to all beneficiaries.

2. Analysis of Major Public Comments

One commenter suggested that the health care finder should refer beneficiaries to both network and non-network sources of care, as appropriate for the particular case, and that health care finder staff be experienced, so that beneficiaries may be properly directed.

Response. We do not foresee circumstances in which health care finders would routinely refer beneficiaries to non-network providers. It is in the beneficiary's interest to use a network provider, because of reduced cost sharing, guaranteed participation, and enhanced quality assurance provisions; it is also in the Government's interest to maximize use of network providers, whose services are provided at preferred rates. Of course, health care finders will attempt to assist beneficiaries in finding non-network sources if no network provider is available; this is likely to be an unusual occurrence, because networks typically will have the full range of CHAMPUS authorized services available.

Health care finder staff will be qualified in their areas of responsibility, often with Registered Nurses providing referral services and appropriately trained clerical staff providing administrative support and services.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

J. General Quality Assurance, Utilization Review, and Preauthorization Requirements (Section 199.17(j))

1. Provisions of Proposed Rule

This paragraph emphasizes that all requirements of the CHAMPUS basic program relating to quality assurance, utilization review, and preauthorization of care apply to the CHAMPUS component of Prime, Extra and Standard. These requirements and procedures may also be made applicable to MTF services.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

K. Pharmacy Services, Including Special Services in Base Realignment and Closure Sites (Section 199.17(k))

1. Provisions of Proposed Rule

This paragraph establishes two special pharmacy programs, a retail pharmacy network program and a mail service pharmacy program.

An important aspect of the mail service and retail pharmacy programs is that, under the authority of section 702 of the National Defense Authorization Act for Fiscal Year 1993, Pub. L. 102–484, there is a special rule regarding eligibility for prescription services. The special rule is that Medicare-eligible beneficiaries, who are normally ineligible for CHAMPUS, are under certain special circumstances eligible for the pharmacy programs. The special circumstances are that they live in an area adversely affected by the closure of an MTF. A provision of the National Defense Authorization Act for Fiscal Year 1995 additionally provides eligibility for Medicare eligible beneficiaries who demonstrate that they had been reliant on a former MTF for pharmacy services.

Under the rule, the area adversely affected by the closure of a facility is established as the catchment area of the treatment facility that closed. The catchment area is the existing statutory designation of the geographical area primarily served by an MTF. The catchment area is defined in law as ''the area within approximately 40 miles of a medical facility of the uniformed services.'' Public Law 100–180, sec. 721(f)(1), 10 U.S.C.A. 1092 note. This is also the geographical basis in the law for nonavailability statements that authorized CHAMPUS beneficiaries who live within areas served by military hospitals to obtain care outside the military facility. 10 U.S.C. 1079(a)(7). Because the purpose of the special eligibility rule for Medicare-eligible beneficiaries is to replace the pharmacy services lost as a consequence of the base closure, and because the 40-mile catchment area is the only geographical area designation established by law to describe the beneficiaries primarily served by a military medical facility, we believe it most appropriate to adopt the established 40-mile catchment area for purposes of the applicability of the special eligibility rule for pharmacy services. Thus, under the rule, Medicare-eligible beneficiaries who live within the established 40-mile catchment area of a closed medical treatment facility are eligible to use the pharmacy programs if available in that area.

There are several noteworthy special rules regarding the area that will be considered adversely affected by the closure of an MTF. First, a 40-mile catchment area generally will apply in the case of the closure of a military clinic, as it does in the case of the closure of a hospital. Recognizing that there may be clinic closure cases involving very small clinics that were not providing any significant amount of pharmacy services to retirees, their family members and survivors, these cases will not be considered to be areas adversely affected by the closure of an MTF. The reason for this is simply that if the facility was not providing a significant amount of services, its closure will not have a noteworthy adverse effect in the area.

The Director, Office of CHAMPUS, may establish other procedures for the effective operation of the pharmacy programs, dealing with issues such as encouragement of the use of generic drugs for prescriptions and of appropriate drug formularies, as well as establishment of requirements for

demonstration of past reliance on an MTF for pharmacy services.

2. Analysis of Major Public Comments

One public comment urged prompt action to implement the program in base closure sites; another commenter suggested establishment of a timetable for defining eligibility and documentation requirements. Another recommended that the definition of beneficiaries affected by the closure of an MTF not be limited to the 40-mile catchment area. Another recommended that eligible Medicare beneficiaries should include all who used the closed pharmacy within the past 12 months.

Response. We agree with the comments provided, and have clarified in the final rule the special rules for eligibility of Medicare beneficiaries for this program.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except that it clarifies the procedures for establishing eligibility for Medicare beneficiaries who live outside the former catchment area of a closed facility. Medicare beneficiaries who obtained pharmacy services at a facility in its last 12 months of operation (or the last twelve months during which pharmacy services were available to non-active duty beneficiaries) will be deemed to have been reliant on the facility; they can establish their reliance through a written statement to that effect.

The pharmacy provisions of the rule are part of the Department's efforts to consolidate its pharmacy programs, and move towards a uniform pharmacy component for TRICARE.

L. PRIMUS and NAVCARE Clinics (Section 199.17(1))

1. Provisions of Proposed Rule

The proposed rule added a new section 199.17(1). Under the authority of 10 U.S.C. sections 1074(c) and 1097, this section would authorize PRIMUS and NAVCARE Clinics, which have operated to date under demonstration authority. This provision would have made permanent the PRIMUS and NAVCARE Clinic authority.

In the proposed rule, we proposed that PRIMUS and NAVCARE Clinics would function in a manner similar to MTF clinics that, as under the demonstration project. As such, all beneficiaries eligible for care in MTFs (including active duty members, Medicare-eligible beneficiaries, and other non-CHAMPUS eligible beneficiaries) would be eligible to use PRIMUS and NAVCARE Clincis. For PRIMUS and NAVCARE Clinics established prior to October 1, 1994, CHAMPUS deductibles and copayments would not apply. Rather, military hospital policy regarding beneficiary charges would apply. For PRIMUS and NAVCARE Clinics established after September 30, 1994, the provisions of the Uniform HMO Benefit regarding outpatient cost sharing would apply (see section 199.18(d)(3)). Other CHAMPUS rules and procedures, such as coordination of benefits requirements would apply. The Director, OCHAMPUS, could waive or modify CHAMPUS regulatory requirements in connection with the operation of PRIMUS and NAVCARE Clinics.

2. Analysis of Major Public Comments

Several commenters sought Clarification of the fees applicable to PRIMUS and NAVCARE clinics established after September 30, 1994, whether Medicare eligibles would be allowed to use the clinics or even enroll in TRICARE using PRIMUS or NAVCARE clinics as primary care managers, and whether PRIMUS and NAVCARE clinics will be limited to space-available care for non-enrollees.

Response. The Department has determined that no new PRIMUS or NAVCARE Clinics will be established, so the distinction made in the proposed rule between existing and new clinics is no longer necessary. As TRICARE is implemented over the next few years, existing PRIMUS and NAVCARE Clinics will be phased out; PRIMUS and NAVCARE Clinics may be converted into TRICARE Outpatient Clinics, as described below, or similar clinics may emerge as components of the managed care support contractor's network. TRICARE Outpatient Clinics will be Army, Navy or Air Force military medical treatment facilities (MTFs): the Government will operate the facilities, credential providers, and be liable for care provided therein; the clinic will be staffed with military personnel, civilian Federal employees, or contractors, or a combination of these; the clinic providers will be direct care primary care managers for TRICARE enrollees (see section 199.17(n)(1)); access priority for care in TRICARE Outpatient Clinics will be the same as for MTFs (see section 199.17(d)(1)); cost sharing for services in TRICARE Outpatient Clinics will be the same as in MTFs (see section 199.17(m)(6)); and collections from third-party insurance will be under the provisions of 32 CFR Part 220, which establishes rules for collections by facilities of the Uniformed Services. Incidentally, the Department is developing a financing approach for TRICARE in which MTF funding will be based on a capitated payment per person enrolled with an MTF primary care manager, and TRICARE managed care support contractors will receive a capitated payment per enrollee with a civilian primary care manager. Under this approach, it is our intention to include funding of TRICARE Outpatient Clinics within the MTF capitation, so that their operation will be a part of the direct care system rather than part of the managed care support contract. Any outpatient clinics or similar facilities established or operated by TRICARE managed care support contractors will be components of the civilian provider network, and will utilize the cost sharing requirements specified in section 199.18(d)(3), which establishes outpatient cost sharing requirements for the Uniform HMO Benefit. These include specific dollar copayments for physician office visits and other routine care, mental health visits, ambulatory surgery services, and prescription drugs, as well as cost sharing percentages for durable medical equipment.

Medicare-eligible military beneficiaries will be eligible for care in TRICARE Outpatient Clinics on a space-available basis, but they will not be allowed to enroll in TRICARE Prime (see section 199.17(a)(6)(i)(D)), unless they have dual CHAMPUS-Medicare eligibility.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except that it is clarified that operation of a PRIMUS and NAVCARE Clinic will cease upon initiation of a TRICARE program in the location of the PRIMUS or NAVCARE Clinic.

M. Consolidated Schedule of Beneficiary Charges (Section 199.17(m))

1. Provisions of Proposed Rule

This paragraph establishes a consolidated schedule of beneficiary charges applicable to health care services under TRICARE for Prime enrollees (other than active duty members), Standard participants; and Medicare-eligible beneficiaries. The schedule of charges is summarized at Table 1, following the preamble. As demonstrated by the table, TRICARE provides for reduced beneficiary out-of-pocket costs.

Included in the consolidated schedule of beneficiary charges is the ''Uniform HMO Benefit'' design required by law. This is further discussed in the next section of the preamble.

2. Analysis of Major Public Comments

One commenter noted the perception of many military beneficiaries that they were promised perpetual free care for their families when they joined the military service. Several commenters representing beneficiaries raised objections to the preamble section describing DoD's plans to consider user fees in MTFs, for some categories of beneficiaries and for some types of care. One commenter pointed out that mental health cost sharing was not addressed in the schedule, and that cost sharing for Medicare-eligible beneficiaries is unclear. Another commenter questioned whether retirees with service-connected disabilities, who in some cases receive treatment for their condition in MTFs, are in effect being charged for this care via the enrollment fee for TRICARE Prime.

Response. Regarding promises of perpetual free care and the preamble material regarding potential future imposition of fees for certain services in MTFs, we would point out that some elements of the MHSS, notably CHAMPUS, have always had beneficiary charges associated with them, and there has never been a system of unlimited free health care for family members and other beneficiaries. In considering options for the Uniform HMO Benefit, we considered imposition of fees in MTF's; because of the high volume of services provided there, a very small fee could have a dramatic impact on other cost sharing requirements necessary to meet the statutory requirements for budget neutrality. It was decided that we would not propose MTF fees in this rulemaking proceeding, but describe some of the considerations regarding such fees in the preamble to set the stage for a possible future rulemaking action.

Regarding mental health cost sharing, we would point out that the Consolidated Schedule of Beneficiary Charges includes several references to the TRICARE Triple Option cost sharing schedule, and the Uniform HMO Benefit Schedule, where mental health cost sharing requirements are described in detail.

Regarding cost sharing for Medicare beneficiaries, the rules of the Medicare program will generally apply for civilian care (with exceptions under PRIMUS and NAVCARE clinics, the special pharmacy program, and certain resource sharing agreements). The details of cost sharing for private sector services, prescribed under the Medicare program, are not presented here, but are available from any Social Security Administration Office.

Regarding beneficiaries with service-connected disabilities, they may elect to enroll in TRICARE Prime, or continue to exercise their entitlements to CHAMPUS, and to space-available care in MTF's or to receive priority care from Department of Veterans Affairs Medical Centers.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

N. Additional Health Care Management Requirements Under Prime (Section 199.17(n)

1. Provisions of Proposed Rule

This paragraph describes additional health care management requirements within Prime, and establishes the point-of-service option, under which CHAMPUS beneficiaries retain the right to obtain services without a referral, albeit with higher cost sharing. Each CHAMPUS-eligible enrollee will select or be assigned a Primary Care Manager who typically will be the enrollee's health care provider for most services, and will serve as a referral agent to authorize more specialized treatment, if needed. Health Care Finder offices will also assist enrollees in obtaining referrals to appropriate providers. Referrals for care will give first priority to the local MTF; other referral priorities and practices will be specified during the enrollment process.

2. Analysis of Major Public Comments

One commenter noted that enrollees would access MTF care only through their primary care manager, while non-enrollees could seek MTF care unfettered. This would limit access for enrollees to routine care at MTFs and to the additional services sometimes available in MTFs. Additionally, the commenter suggested that variations in MTF primary care capacity in different locations would create disparities in benefits and in access to MTF services.

Another commenter recommended that patient access to his/her medical specialist of choice be guaranteed, and that beneficiaries not be forced to be evaluated and treated for mental illness by non-physicians.

A commenter representing beneficiaries asked how far enrollees could be required to travel outside the area if needed care was unavailable locally.

One commenter questioned how referrals outside the network or area would be carried out, and how beneficiaries would obtain approval for such care.

Response. It is true that the capacity and capabilities of the direct care system of MTFs vary across the country, and that this creates some disparities in access to free health care services. The basic entitlement to CHAMPUS (or to Medicare) fills in many of the ''gaps'' arising from this circumstance; the Government shares in the costs of civilian health care obtained by beneficiaries. TRICARE attempts to further ameliorate disparities in access and cost through creation of an integrated military-civilian health care program. Under TRICARE Prime, outpatient care continues to be free in MTFs, and the Government assumes a greater share of the cost of civilian health care services. It is our firm belief that under a managed health care approach, beneficiaries will receive much better access to needed health care services than they do under the existing approach, in which MTF care and civilian care are largely uncoordinated.

Regarding the comments about access to specialist of choice, requirements to travel to receive care, and referrals for out-of-network care, we emphasize that one of the key features of TRICARE Prime is the assignment of a primary care manager for each enrollee. The primary care manager, supported by the Health Care Finder, will be responsible for providing or arranging all nonemergency care for the enrollee. As specified in section 199.17(n)(2)(iii)(C), when needed referral care is unavailable in MTF, the enrollee will have the freedom to choose a provider from among those in the civilian network, subject to availability. Beneficiaries will be authorized to receive care from providers not affiliated with the network in cases where neither military facilities nor the civilian network can provide the care, pursuant to section 199.17(n)(2)(iii)(E). Mandatory referrals necessitating travel are also addressed in section 199.17(n)(2): they can be required only if the enrollee was informed of the policy at or prior to enrollment. Travel will not be reimbursed, except in the context of the Specialized Treatment Services program. See 32 CFR 199.4(a)(10) and 58 FR 58955 for further information about that program.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

O. Enrollment Procedures (Section 199.17(o))

1. Provisions of Proposed Rule

This paragraph describes procedures for enrollment of beneficiaries other than active duty members, who must enroll. The Prime plan features open season periods during which enrollment is permitted. Prime enrollees will maintain participation in the plan for a 12 month period, with disenrollment only under special circumstances, such as when a beneficiary moves from the area. A complete explanation of the features, rules and procedures of the Program in the particular locality involved will be available at the time enrollment is offered. These features, rules and procedures may be revised over time, coincident with reenrollment opportunities.

2. Analysis of Major Public Comments

One commenter asked us to define the ''significant effect on participant's costs or access to care'' which would trigger an opportunity to change enrollment status under 199.17(0)(3).

One commenter asked if the installment method would be available for payment of the enrollment fee, and urged that no maintenance fee apply if so.

Response. Regarding definition of ''significant effect'' on costs or access, which would trigger an opportunity to change enrollment status, we define a significant effect as follows: a change in cost sharing or access policy expected to result in an increase in average annual beneficiary out-of pocket costs of $100 or more.

Regarding installment payment of enrollment fees, a provision has been added to authorize installment payments; we hope to offer allotment payments in the future. While the rule provides only a general provision in this regard, we would point out that current practice in TRICARE is to offer a quarterly payment option, with the option to pay the full amount remaining at any time; an additional charge of $5.00 is added to each periodic payment to cover the additional administrative costs associated with the installment method. Some beneficiaries have expressed concern about the inclusion of such a ''maintenance fee.'' Our position is that, given that the enrollment fee has been set at the minimum amount needed to comply with statutory requirements of budget neutrality, we cannot ignore the additional costs associated with installment payment methods. We believe it is appropriate, and consistent with private sector practice, to add a small amount to each payment, rather than to spread this cost across all beneficiaries who enroll in TRICARE Prime.

The rule also includes exclusion from TRICARE Prime for one year for failure to make an installment payment on a timely basis, including a grace period. Eligibility for TRICARE Standard and Extra would be unaffected by the exclusion penalty.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, with several exceptions. Provisions regarding open season enrollment have been broadened to include continuous open enrollment, wherein beneficiaries may enroll at any time, and each enrollee has an individualized, specific anniversary date. In addition, provisions have been added regarding the installment payment option.

P. Civilian Preferred Provider Networks (Section 199.17(p))

1. Provisions of Proposed Rule

This paragraph sets forth the rules governing civilian preferred provider networks in the TRICARE Program. It includes conformity with utilization management and quality assurance program procedures, provider qualifications, and standards of access for provider networks. In addition, the methods which may be used to establish networks are identified.

DoD beneficiaries who are not CHAMPUS-eligible, such as Medicare beneficiaries, may seek civilian care under the rules and procedures of their existing health insurance program. Providers in the civilian preferred provider network generally will be required to participate in Medicare, so that when Medicare beneficiaries use a network provider they will be assured of a participating provider.

2. Analysis of Major Public Comments

Two public comments indicated that the requirement for providers to accept Medicare assignment would adversely affect network development, one suggesting that the requirement was unlawful and repugnant. One commenter indicated that reductions in CHAMPUS payment amounts in recent years will make it increasingly difficult to establish and maintain an adequate network of providers, leading to lower quality providers and dissatisfaction on the part of beneficiaries.

One commenter pointed out that some categories of providers, while not ineligible for Medicare participation, have not participated in Medicare because it is irrelevant to their lines of business. The commenter suggested that, in such cases, the requirement to participate in Medicare should not apply.

One commenter objected to the requirement that preferred providers must meet all other qualifications and requirements, and agree to comply with all other rules and procedures established for the network, suggesting that any such additional requirements must be subjected to the rulemaking process.

One commenter questioned the lack of specificity in 199.17(p)(6) regarding special reimbursement methods for network providers, and recommended additional specificity in the final rule. Another commenter recommended that the rule specify if rate setting methods for network providers will be the same as in standard CHAMPUS, and that any differences in rate setting for the ''any qualified provider method'' be made subject to the rulemaking process.

One commenter recommended that network requirements specify the inclusion of psychiatrists, allowed to provide a full range of diagnostic and treatment services.

One commenter urged that we require that the network contain a sufficient number and mix of all provider types, not just physicians, and explicitly prohibit discrimination against a health care provider solely on the basis of the professional's licensure or certification, to prohibit exclusion of an entire class of health care professional.

One commenter asked who would pay for travel or overnight accommodations if a beneficiary must travel more than 30 minutes from home to a primary care delivery site.

One commenter asked why 199.17(p)(5)(ii) allows a four-week wait for a well-patient visit, and a two-week wait for a routine well-patient visit.

One commenter suggested that the wide latitude in network development methods provided by 199.17(p)(7) would create undesirable inconsistencies across the nation.

One commenter suggested that any qualified provider be allowed into the preferred provider network, regardless of the method used to develop the network.

One commenter recommended that the rule specify if rate setting methods for network providers will be the same as in standard CHAMPUS, and that any differences in rate setting for the any qualified provider method be made subject to the rulemaking process.

Response. Regarding the requirement that providers accept Medicare assignment as a condition of

participation in the TRICARE network, we believe that this requirement is reasonable. Payment amounts under the CHAMPUS and Medicare programs are very similar, so there would not seem to be an economic issue involved. The vast majority of physicians nationally (83 percent in 1993) already participate in Medicare, so there should be a large pool of providers available. For hospitals, CHAMPUS and Medicare participation is linked by statute. Physician participation is not linked for the standard CHAMPUS program, but in the context of establishing a managed care network is entirely appropriate and consistent with statutory authority to establish reasonable requirements for network providers, including acceptance of Medicare assignment.

Regarding the suggestions that some providers may not be Medicare participating providers because it is irrelevant to their line of business, and thus should be exempted from the requirement, we agree that there may be some classes of providers which, while providing services of importance to CHAMPUS beneficiaries, provide no services covered by Medicare. Such a case may be covered by the waiver for ''extraordinary circumstances'' which is included in this provision.

Regarding the comment that any additional requirements established for network providers should be subject to the rule making process, we point out that this provision refers to additional, local requirements established for network providers, consistent with the program-wide rules established in this regulation and other program documents. Further rulemaking activity in this regard is neither necessary nor appropriate.

Regarding the suggestion that we provide additional specificity concerning the special reimbursement methods for network providers, we do not agree that additional specifics should be provided. The rule provides added flexibility to vary payment provisions from those established by regulation, to accommodate local market conditions. To attempt to specify in advance the possible reimbursement approaches would defeat our purpose of providing a flexible mechanism. We also disagree that network rate setting should be the same as under standard CHAMPUS rules; a key aim of managed care programs is to negotiate lower rates of reimbursement with networks of preferred providers.

Regarding the comments which recommended specification of provider types to be included in the network, or suggested anti-discrimination provisions, we point out that section 199.17(p)(5) requires that the network have an adequate number and mix of providers such that, coupled with MTF capabilities, it can meet the reasonably expected health care needs of enrollees. Beneficiaries will have available the full range of needed health care services, and network managers will be responsible for arranging to meet any unanticipated health care needs which cannot be accommodated in the network. We do not think it is appropriate to specify which provider types and how many will be included in the network, because this will vary by location, depending on beneficiary demographics and local health care marketplace conditions.

Regarding payment for travel or overnight accommodations if a beneficiary must travel more than 30 minutes from home to a primary care delivery site, we will not make such payments. Payment for travel is authorized only in association with the specialized treatment services program, under section 199.4(a)(10).

Regarding why 199.17(p)(5)(ii) allows a four-week wait for a well-patient visit, and a two-week wait for a routine well-patient visit, this was a typographical error in the proposed rule. The provision should be, a four-week wait for a well-patient visit, and a one-week wait for a routine visit.

Regarding the comment that the wide latitude in network development methods provided by 199.17(p)(7) would create undesirable inconsistencies across the nation, we point out that a single method is being implemented nationally: competitive solicitation of regional TRICARE support contractors. We expect that alternative methods will be used only to address special circumstances.

Regarding the suggestion that any qualified provider be allowed into the preferred provider network, regardless of the method used to develop the network, we disagree. The rule contains provisions (section 199.17(q)) for using such a method, but our preferred method, which we are implementing, is to establish regional TRICARE support contracts on a competitive basis, with offerors proposing a selective provider network.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except for correction of a typographical error; the rule now specifies maximum wait time for a routine visit of one week.

Q. Preferred Provider Network Establishment Under Any Qualified Provider Method (Section 199.17(q))

1. Provisions of Proposed Rule

This paragraph describes one process that may be used to establish a preferred provider network (the ''any qualified provider method'') and establishes the qualifications which providers must demonstrate in order to join the network.

2. Analysis of Major Public Comments

Several commenters urged that the ''any qualified provider'' method not be used in the development of managed care network for DoD.

One commenter recommended that the requirement that providers follow all quality assurance and utilization management procedures established by OCHAMPUS be linked to the requirement that providers must meet all other rules and procedures that are established, publicly announced, and uniformly applied.

Response. As provided in section 199.17(p)(7), there are several possible methods for establishing a civilian preferred provider network, including competitive acquisitions, modification of and existing contract, or use of the ''any qualified provider'' approach described in section 199.17(q). The current method of choice in implementing TRICARE is the first approach: DoD plans to award several regional managed care support contracts in the next few years. The managed care support contractors will establish the civilian provider networks according to the requirements specified in the government's request for proposals (RFP) for each procurement; these RFP requirements will be consistent with the provisions of section 199.17(p). At this point, we do not anticipate any broad use of the ''any qualified provider'' approach; it could be used under special circumstances, however.

A commenter suggested that we link two of the ''any qualified provider'' requirements—section 199.17(q)(2), which specifies that providers must meet all quality assurance and utilization management requirements established pursuant to section 199.17, and section 199.17(q)(4), which requires that providers follow all rules and procedures established, publicly announced and uniformly applied by the commander or other authorized official. A linkage is not appropriate. The former requirement specifically emphasizes some of nationally established regulatory requirements will apply to providers under the ''any qualified provider'' approach. The latter

requirement enables establishment of additional, uniform, local requirements for the ''any qualified provider'' approach. These could include, for example, a requirement for a five percent discount off prevailing CHAMPUS payment amounts, applicable to all providers in the network. The amount of discount feasible would depend on local market conditions and the degree of military presence in the community, hence it would be more appropriate as a local requirement than a nationally established standard.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

R. General Fraud, Abuse, and Conflict of Interest Requirements Under TRICARE Program (Section 199.17(r))

1. Provisions of Proposed Rule

This paragraph establishes that all fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program are applicable to the TRICARE Program.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

S. Partial Implementation of TRICARE (Section 199.17(s))

1. Provisions of Proposed Rule

This paragraph explains that some portions of TRICARE may be implemented separately: a program without the HMO option, or a program covering a subset of health care services, such as mental health services.

2. Analysis of Major Public Comments

One commenter suggested that partial implementation of TRICARE would be inconsistent with the Congressional mandate for a uniform benefit across the country, and urged commitment to full implementation of all TRICARE options in all regions.

Response. We are indeed intent upon implementing TRICARE nationally. It would not be inconsistent with Congressional direction to implement TRICARE partially in a location, given that the Congressional mandate for establishment of the Uniform HMO Benefit is to make it applicable throughout the country, to the maximum extent practicable. If local circumstances were to make full implementation impracticable, it might be preferable to implement at least some features of TRICARE.

One potential circumstance for partial implementation of TRICARE is the offering of TRICARE Prime to selected beneficiary groups in remote sites. This would be consistent with the Congressional direction to implement the Uniform HMO Benefit nationally, to the extent practicable. For example, military recruiters are often assigned to duty in locations without MTFs, and thus their families may be at a disadvantage in terms of health care cost or access, compared to most families of active duty members.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except that we have clarified that partial implementation of TRICARE may include offering TRICARE Prime to limited groups of beneficiaries in remote sites, and that some of the normal requirements of TRICARE Prime may be waived in this regard.

T. Inclusion of Veterans Hospitals in TRICARE Networks (Section 199.17(t))

This paragraph would provide the basis for participation by Department of Veterans Affairs facilities in TRICARE networks, based on agreements between the VA and DoD.

2. Analysis of Major Public Comments

One public comment was received relating to this section of the rule, applauding the inclusion of VA facilities in TRICARE and urging prompt action to implement the provision.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

U. Cost Sharing of Care for Family Members of Active Duty Members in Overseas Locations (Section 199.17(u))

1. Provisions of Proposed Rule

This paragraph would permit establishment of special CHAMPUS cost sharing rules for family members of active duty members when they accompany the member on a tour of duty outside the United States. A recently initiated demonstration program, described in the Federal Register of September 2, 1994 (59 FR 45668), tests such a program for active duty family members in countries served by OCHAMPUS, Europe.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The Final Rule is consistent with the proposed rule, except that it provides further details of the circumstances under which alternatives to CHAMPUS cost sharing rules may be approved, in the context of management care programs in overseas locations. Programs will include networks of providers who have agreed to accept CHAMPUS assignment for all care. Beneficiary cost sharing for care obtained from network providers will be zero.

V. Administrative Procedures (Section 199.17(v))

1. Provisions of Proposed Rule

This paragraph authorizes establishment of administrative procedures for the TRICARE Program.

2. Analysis of Major Public Comments

One commenter asked whether MTF billing of other primary health insurance would continue under TRICARE.

Response. MTF billing of third party insurance, governed by provisions of 32 CFR Part 220, will continue under TRICARE.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

III. Provisions of the Rule Concerning the Uniform HMO Benefit Option

A. In General (Section 199.18(a))

1. Provisions of Proposed Rule

This paragraph introduces the Uniform HMO Benefit option. The statutory provision that establishes the parameters for determination of the Uniform HMO Benefit option is section 731 of the National Defense Authorization Act for Fiscal Year 1994. It requires the establishment of a Uniform HMO Benefit option, which shall ''to the maximum extent practicable'' be included ''in all future managed health care initiatives undertaken by'' DoD. This option is to provide ''reduced out-of-pocket costs and a benefit structure that is as uniform as possible throughout the United States.'' The statute further requires a determination that, in the managed care initiative that includes the Uniform HMO Benefit, DoD costs ''are no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the option.''

In addition to this provision of the National Defense Authorization Act for Fiscal Year 1994, a similar requirement

is established by section 8025 of the DoD Appropriations Act, 1994. As part of an initiative ''to implement a nationwide managed health care program for the MHSS,'' DoD shall establish ''a uniform, stabilized benefit structure characterized by a triple option health benefit feature.'' Our Uniform HMO Benefit also implements this requirement of law.

In fiscal year 1993, DoD implemented the expansion of the CHAMPUS Reform Initiative to the areas of Carswell and Bergstrom Air Force Bases in Texas and England Air Force Base, Louisiana. (These sites were singled out because they were military bases identified for closure in the Base Realignment and Closure, or ''BRAC'' process; thus the benefit developed for them is called the ''BRAC Benefit.'') This expansion of the CHAMPUS Reform Initiative offers positive incentives for enrollment and preserves the basic design of the original CHAMPUS Reform Initiative program, although it is not identical to that program. The original CHAMPUS Reform Initiative design featured a $5 per visit fee for most office visits, a very much reduced schedule of other copayments, and no deductible or enrollment fee. Although its generosity made it very popular with beneficiaries, it also caused substantial concerns regarding government budget impact. This benefit fails to meet the statutory requirement for cost neutrality to DoD.

The Carswell/Bergstrom/England HMO benefit (BRAC Benefit) model attempts partially to address these concerns, while providing enhanced benefits. It features enrollment fees for some categories of beneficiaries, $5, $10, or $15 per visit fees, depending on beneficiary category, and inpatient per diems of $125 for retirees, their family members and survivors. This benefit also fails to meet the statutory requirement for cost neutrality to DoD.

A new HMO benefit is being presented in this rule as the Uniform HMO Benefit. The principal features of the benefit are displayed in Table 3 following the preamble. Its most significant change from the BRAC Benefit is that inpatient cost sharing for retirees, their family members and survivors is reduced to the levels faced by active duty family members, with concomitant increases in enrollment fees for these beneficiaries. A second important change is that there would be no enrollment fee for family members of active duty members. Finally, fees are set so that if the predicted costs remain valid, they may be held constant for a five-year period, rather than escalating each year with price inflation.

The development of this Uniform HMO Benefit included painstaking analysis of utilization, cost, and administrative effect of potential cost sharing schedules. This analysis included a series of assumptions regarding most likely ramifications of various components of the benefit and the operation of the TRICARE Program. Based on this exhaustive analysis, the formulation of the Uniform HMO Benefit in the rule is the most generous benefit DoD can offer consistent with the statutory cost-neutrality mandate.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

B. Benefits Covered Under the Uniform HMO Benefit Option (Section 199.18(b))

1. Provisions of Proposed Rule

For CHAMPUS-eligible beneficiaries, the HMO Benefit option incorporates the existing CHAMPUS benefit package, with potential additions of preventive services and a case management program to approve coverage of usually noncovered health care services (such as home health services) in special situations.

2. Analysis of Major Public Comments

One commenter suggested that the extent of case management benefits and the circumstances under which they would be provided should be clarified.

Response. Case management of services for CHAMPUS beneficiaries will be addressed in a separate, forthcoming rule making action. We anticipate publication of a proposed rule on this subject later in 1995.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

C. Deductibles, Fees, and Cost Sharing Under the Uniform HMO Benefit Option (Sections 199.18 (c) through (f))

1. Provisions of Proposed Rule

Instead of usual CHAMPUS cost sharing requirements, Uniform HMO Benefit option participants will pay special per-service, specific dollar amounts or special reduced cost sharing percentages, which would vary by category or beneficiary.

The Uniform HMO Benefit also would include an annual enrollment fee, which would be in lieu of the CHAMPUS deductible. The current CHAMPUS deductible is $50 per person or $100 per family for family members of active duty members in pay grades E–1 through E–4; and $150 per person or $300 per family for all other beneficiaries. The enrollment fee under the Uniform HMO Benefit option would vary by beneficiary category: $0 for active duty family members, and $230 individual or $460 family for retirees, their family members, and survivors.

The amount of enrollment fees, outpatient charges and inpatient copayment under the Uniform HMO benefit are presented in detail in sections 199.18 (c) through (f).

2. Analysis of Major Public Comments

Two commenters suggested that high enrollment fees might deter CHAMPUS-eligible retirees, survivors, and their family members from enrolling. One demanded that separate and higher copayments for mental health services be eliminated.

Another commenter indicated that the cost share proposed for durable medical equipment and prostheses, coupled with the catastrophic cap of $7,500 for retirees, survivors and their family members, presented a risk of costs too high, and suggested lowering the catastrophic cap to $2,500.

Another commenter objected to the provision allowing for annual updates in enrollment fees and copayments, since the Uniform HMO Benefit cost sharing was calculated to be constant over a five year period.

One commenter objected to application of enrollment fees to retirees, their survivors, and family members, and not to active duty families and suggested that this represents an inappropriate subsidy.

One commenter noted the requirement that the Uniform HMO Benefit be modeled on private sector HMO plans, and pointed out that the average office visit copayment was $6.23 for in civilian HMOs in 1993, compared to $12 for most beneficiaries under the Uniform HMO Benefit. It was suggested that DoD thus ignored a basic requirement of the statute.

Response. Regarding the suggestion that high enrollment fees might deter CHAMPUS-eligible retirees, survivors, and their family members from enrolling, we recognize that each family has different health care needs and circumstances, and all will not find enrollment in TRICARE Prime as the right choice. However, it does offer a cost-effective alternative to TRICARE Standard, and will be the best option for many people.

Regarding the demand that separate and higher copayment for mental health services be eliminated, we cannot

comply. Cost sharing, utilization management, and other requirements are different for mental health services in standard CHAMPUS, just as they are in many civilian sector health plans. Given the need to craft a benefit design which is cost-effective for beneficiaries and the Government, we found no alternative but to preserve the distinct treatment of mental health services.

Regarding comments about potentially high costs for durable medical equipment and prostheses, we agree, and have lowered the catastrophic cap to $3,000 for retirees, their family members and survivors enrolled in TRICARE Prime.

Regarding objections to the provision allowing for annual updates in enrollment fees and copayments, since the uniform HMO Benefit cost sharing was calculated to be constant over a five-year period, we acknowledge this concern, and are committed to maintaining a stable benefit. We have retained the provision allowing updates, however, because of the statutory direction to administer the Uniform HMO Benefit so the DoD costs are no higher than they would be without the program. If the program is not budget neutral, enrollment fees or other cost sharing will need to be increased, or other actions taken, to assure budget neutrality. We recognize that this is a sensitive issue, and we strongly believe that no increases in enrollment fees will be necessary during the first five years of the program, because we performed exhaustive analysis in arriving at the cost sharing structure, and critically reviewed all the assumptions we made about program performance. Considerations leading to retention of the provision permitting updates to fees include, first, that the enrollment fees in the Uniform HMO Benefit are set at the absolute minimum necessary to comply with the budget neutrality dictates; there is no ''cushion'' built in. Second, the Congressional Budget Office, in reviewing the Uniform HMO Benefit, determined that there is so much uncertainty about the performance of managed care systems that precise predictions are impossible. CBO has formally estimated that the Uniform HMO Benefit will increase DoD's costs of health care delivery, despite the statutory requirement that it be budget neutral, and that total cost will probably increase by about 3 percent. Finally, the implementation of TRICARE over the next several years provides an opportunity to confirm the assumptions we made in establishing the Uniform HMO Benefit.

Regarding objections to application of enrollment fees to retirees, their survivors, and family members, and not to active duty families, and suggestions that this represents an inapporpriate subsidy, we would point out that our analysis considered the costs of retirees, their family members and survivors separately from the costs of active duty family members. There is no subsidy of active duty family members by other beneficiaries inherent in the benefit design; instead the differences in cost sharing reflect the differences established statutorily when CHAMPUS was created in 1966, and revised numerous times since then.

Regarding the comment that we ignored the statutory requirement that the Uniform HMO Benefit be modeled on private sector HMO plans, because its cost sharing requirements were higher in some, we disagree. The Uniform HMO Benefit does include somewhat higher copayment than are used in most private sector HMO plans, owing to the other statutory requirements we must address; however, we feel that the Uniform HMO Benefit is ''modeled'' on HMO plans, because it employs the same approach they do, replacing percentage-based cost sharing with fixed dollar copayment to limit beneficiary out-of-pocket expenses and reduce incentives for over-provision of care. The statute imposes several conflicting requirements for the Uniform HMO Benefit, and our design attempts to ''harmonize'' these requirements to the maximum extent feasible. These include the requirement to model the benefit on private sector plans, the requirement that beneficiary out-of-pocket costs be reduced, and that government costs be no greater than would otherwise be incurred for enrollees. Replicating a typical HMO plan offered in the Federal Employee Health Benefits Program, for example, would violate the out-of-pocket cost provisions, because (although per-visit copayments are very low) annual out-of-pocket costs are much higher than in CHAMPUS owing to much higher premiums. Using the very attractive (low) copayments from one of these plans along with low enrollment fees would violate the requirement for budget neutrality. In a nutshell, the Uniform HMO Benefit design reflects a careful balancing of several statutory requirements; considering any one of them in isolation is inappropriate.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except for one important change. We have revised the benefit in response to concerns about the vulnerability of a small number of retirees to high out-of-pocket costs, owing to the percentage cost share for durable medical equipment, coupled with a catastrophic cap of $7,500 per family. Instead of incorporating the standard CHAMPUS catastrophic cap of $7,500, the Uniform HMO Benefit will include a catastrophic cap of $3,000 for retirees, survivors, and their family members. Thus retirees, survivors, and their family members who enroll in TRICARE Prime will have a considerably lower limit on their annual out-of-pocket expenses, in addition to the dramatically lower per-service charges features in the Uniform HMO Benefit.

D. Applicability of the Uniform HMO Benefit to the Uniformed Service Treatment Facilities Managed Care Program (Section 199.18(q))

1. Provisions of Proposed Rule

The section would apply the Uniform HMO Benefit provisions to the Uniformed Services Treatment Facility Managed Care Program, beginning in fiscal year 1996. This program includes civilian contractors providing health care services under rules quite different from CHAMPUS, the CHAMPUS Reform Initiative, or other CHAMPUS-related programs.

The National Defense Authorization Act for Fiscal Year 1991, section 718(c), required implementation of a ''managed-care delivery and reimbursement model that will continue to utilize the Uniformed Services Treatment Facilities'' in the MHSS. This provision has been amended and supplemented several times since that Act. Most recently, section 718 of the National Defense Authorization Act for Fiscal Year 1994 authorized the establishment of ''reasonable charges for inpatient and outpatient care provided to all categories of beneficiaries enrolled in the managed care program.'' This is a deviation from previous practice, which had tied Uniformed Services Treatment Facilities (USTF) rules to those of MTFs. This new statutory provision also states that the schedule and application of the reasonable charges shall be in accordance with terms and conditions specified in the USTF Managed Care Plan. The USTF Managed Care Plan agreements call for implementation in the USTF Managed Care Program of cost sharing requirements based on the level and range of cost sharing required in DoD managed care initiatives.

The Conference Report accompanying National Defense Authorization Act for Fiscal Year 1994 calls on DoD ''to develop and implement a plan to introduce competitive managed care

into the areas served by the USTFs to stimulate competition'' among health care provider organizations ''for the cost-effective provision of quality health care services.'' We have determined that it is most appropriate to use the Uniform HMO Benefit for the USTF Managed -Care Program. This action will stimulate competition between the USTFs and firms operating the other DoD managed care program to which the Uniform HMO Benefit applies. Based on these considerations, we proposed to include the USTF Managed Care Program under the Uniform HMO Benefits, effective October 1, 1995.

2. Analysis of Major Public Comments

One commenter asked if Medicare-eligible beneficiaries currently enrolled in the USTF managed care program will continue to be enrolled after October 1, 1995.

One commenter suggested that tying the USTF program to TRICARE was inappropriate, arbitrary, and should be done only after direct notice to those beneficiaries who would be affected. Another commenter indicated that it was inappropriate to increase cost sharing for USTFs while exempting PRIMUS and NAVCARE clinics.

One commenter suggested that the use of the rulemaking process for establishing cost sharing in Uniformed Services Treatment Facilities (USTFs) commits DoD to using the rulemaking process for addressing USTF cost sharing in the future.

One commenter took issue with the applicability of Section 731 of the National Defense Authorization Act for Fiscal Year 1994 to USTFs, since it applies to ''health care initiatives undertaken * * * after the date of enactment of the act,'' and services were initiated under the USTF managed care program prior to that time. Also, the commenter questioned whether Congressional Conference report language recommending the introduction of competitive managed care into areas now served by USTFs justifies imposing the TRICARE costs shares (i.e., the Uniform HMO Benefits) on USTFs.

One commenter suggested that the statute directing the Uniform HMO Benefit provides latitude for differences in cost sharing requirements, because it specifies only reduced out of pocket costs for enrollees, and mandates uniformity in the range of health care services to be available to enrollee. Focusing on the requirement for reduced out-of-pocket costs, the commenter notes that out-of-pocket costs for USTF enrollees would be increased substantially under the Uniform HMO Benefit. Because applying the Uniform HMO Benefit cost sharing to USTFs would be inappropriate and unnecessary, and because the range of health care services in CHAMPUS and the USTF program are similar, the commenter suggests that proposed § 199.18(g) not be included in the final rule.

One commenter suggested that the separate, capitated arrangements between the Government and USTFs meet the requirement that the costs incurred by the Secretary under each managed care initiative be no greater than would otherwise be incurred. It is argued that, because USTFs are fully at risk for excess health care costs, the Uniform HMO Benefit cost sharing is unnecessary for the USTF program.

3. Provisions of the Final Rule

We have deleted as unnecessary this provision of the final rule. The USTF managed care plan agreements provide for adoption of the DoD policy for cost sharing under managed care programs. Thus, incorporation of the Uniform HMO Benefit, which now has been promulgated as DoD policy for managed care programs, into the USTF managed care plan has already been provided for through contractual agreement and need not be repeated in this regulation.

DoD's policy is to phase the uniform HMO benefit into the USTF program, coincident with implementation of the TRICARE regional managed care contract in the respective area. This will assure equitable treatment for beneficiaries within a region and nationality. Eventually, USTFs would be fully integrated into the TRICARE system, on an equal footing with other contract providers of health care. The intention is to provide a level playing field for the operation of managed care programs, and to assure equity among beneficiaries.

IV. Provisions of the Rule Concerning Other Regulatory Changes

The rule makes a number of additional changes to support implementation of TRICARE.

A. Nonavailability Statements (Revisions to Sections 199.4(a)(9) and 199.15)

1. Provisions of Proposed Rule

Proposed revisions to section 199.4 relate to the issuance of NASs by designated military clinics. Beneficiaries residing near such designated clinics would have to obtain a nonavailability statement for the selected outpatient services subject to NAS requirements under section 199.4(a)(9)(i)(C).

In a notice of proposed rule making published on May 11, 1993, we proposed a new provision to allow consideration of availability of care in civilian preferred provider networks in connection with issuance of non-availiability statements; in conjunction with this, a considerable expansion of the list of outpatient services for which an NAS is required was proposed. That proposal was not finalized. In the proposed rule, we outlined a more limited program, covering only inpatient care. Recently, a demonstration program was established in California and Hawaii, allowing consideration of availability of care in civilian preferred provider networks in connection with issuance of non-availability statements for inpatient services only. The results of the demonstration will be incorporated into a Report to Congress on the expanded use of NASs, as required by section 735 of the National Defense Authorization Act for FY 1995.

Finally, proposed revisions to section 199.4(a)(9) would apply NAS requirements in cases where military providers serving at designated military outpatient clinics also provide inpatient care to beneficiaries at civilian hospitals, under External Partnership or Resource Sharing Agreements.

2. Analysis of Major Public Comments

Several commenters objected to the notion of employing non-availability statements under TRICARE, since beneficiaries are being given the choice of enrolling the TRICARE Prime or exercising their benefit under TRICARE Standard with higher cost shares accompanied by freedom of choice.

One commenter recommended that NAS requirements be uniform throughout the nation, to avoid confusing the highly mobile beneficiary population.

Several commenters suggested that requiring non-enrolled beneficiaries to use network providers or civilian facilities with an external partnership or resource sharing agreement, through issuance of a ''restricted'' NAS, was unfair to those unable to enroll in TRICARE Prime, and to those with chronic conditions who might have long-standing provider relationships.

One commenter sought clarification of the applicability of the restricted NAS provisions to beneficiaries under TRICARE Prime, Extra, and Standard and suggested that restricting use of non-network care by TRICARE Standard beneficiaries is an unreasonable curb on their freedom of choice, as well arbitrarily preventing an authorized CHAMPUS provider from furnishing

care to qualifying CHAMPUS beneficiaries. One commenter suggested that limiting freedom of choice of civilian provider for TRICARE Standard beneficiaries through the ''restricted NAS'' provisions of 199.4(a)(9) would be unlawful.

One commenter objected to the use of the provisions for external partnership or resource sharing for mental health care, suggesting that it would be inappropriate mental health services because military mental health providers would provide limited interventions, disrupting care for mental health patients, particularly children and adolescents. Also, the commenter suggested that use of this provision would deny beneficiaries their right to seek care from any qualified CHAMPUS-authorized providers in the catchment area.

One commenter suggested that we define the terms for exceptions to the restricted NAS provision related to ''exceptional hardship'' or ''other special reason,'' recommending that special reason include that more effective or appropriate care is available, and that hardships include financial and geographic hardships.

Response. We acknowledge that there is a legitimate point of view that TRICARE Standard, as the fee-for-service type option, should provide total freedom of choice of provider. However, the requirement that beneficiaries determine whether nearby MTFs can provide a needed service, before obtaining it from a civilian source, is important to the vitality of military medicine and the maintenance of medical readiness training for wartime.

Regarding the recommendation that NAS requirements be uniform throughout the nation, to avoid confusing the highly mobile beneficiary population, we agree, in the main. The only exceptions to nationally standard NAS requirements are those imposed in the context of the specialized treatment services program, wherein catchment areas of up to 200 miles surrounding a service site may be established for highly specialized, high cost services.

Regarding the comments that requiring non-enrolled beneficiaries to use network providers or civilian facilities with an external partnership or resource sharing agreement, through issuance of a ''restricted'' NAS, would be unfair to some beneficiaries, we point out that these NAS requirements in the proposed rule related to inpatient care and a limited, specific list of outpatient procedures. The requirements would not limit beneficiary freedom to choose a provider for most care, particularly care for chronic conditions.

Regarding the request for clarification of the applicability of the restricted NAS provisions, the proposed rule would have applied these to all CHAMPUS-eligible beneficiaries. Regarding the comment that restricting use of non-network care by TRICARE Standard beneficiaries would represent an unreasonable curb on their freedom of choice, we point out, as above, that these provisions apply to a very limited subset of care, and would not impede choice of provider in most cases. Regarding the comment that the restricted NAS would arbitrarily prevent an authorized CHAMPUS provider from furnishing care to qualifying CHAMPUS beneficiaries, this is true in a sense, for the very limited array of services covered. However, many rules and requirements are applicable to the provision and reimbursement of health care services under CHAMPUS, and we believe this limited extension of NAS requirements, specifically authorized by law, would not be arbitrary. Regarding the suggestion that limiting freedom of choice of civilian provider for TRICARE Standard beneficiaries (199.17(a)(6)(ii)(C)) through the ''restricted NAS'' provisions of 199.4(a)(9) would be unlawful, we would point out that the application of NAS requirements to services available in civilian provider networks is authorized under 10 U.S.C. section 1080(b).

Regarding objections to the use of provisions for external partnership or resource sharing for mental health care, again, we point out that the only services to which these proposed requirements would have applied are those subject to normal NAS requirements: inpatient admissions and a limited set of outpatient technical procedures. They would not disrupt ongoing relationships with civilian providers.

Regarding the suggestion that we define the terms for exceptions to the restricted NAS provision related to ''exceptional hardship'' or ''other special reason,'' we agree with the commenters that the availability of more effective or appropriate care would constitute a valid reason for a determination that denying the NAS would be medically inappropriate. Also, we agree that the concept of hardship should include financial and geographic hardships.

3. Provisions of the Final Rule

Provisions regarding the ''restricted NAS'' have been deleted from the final rule. Our current plan is to evaluate the results of the California/Hawaii demonstration project, consider the desirability of expanding the activity more broadly, and report to Congress on our conclusions. Should we decide to go forward with some use of the restricted NAS authority, we would initiate a new rulemakng proceeding.

The expanded authority pertaining to outpatient NASs for a limited set of procedures at a limited number of highly capable outpatient clinics is included in the final rule, consistent with the proposed rule.

B. Participating Provider Program (Revisions to 199.14)

1. Provisions of Proposed Rule

Revisions to section 199.14 change the Participating Provider Program from a mandatory, nationwide program to a localized, optional program. The initial intent of the program was to increase the availability of participating providers by providing a mechanism for providers to sign up as Participating Providers; a payment differential for Participating Providers was to be added as an inducement. With the advent of the TRICARE Program and its extensive network of providers, the nationwide implementation of the Participating Provider Program would be redundant. Accordingly, this rule would eliminate the nationwide program. Where the need arises, CHAMPUS contractors will act to foster participation, including establishment of a local Participating Provider Program when needed, but not including the payment differential feature.

2. Analysis of Major Public Comments

No public comments were received relating to this section of the rule.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

C. Administrative Linkages of Medical Necessity Determinations and Nonavailability Statement Issuance (Revisions to 199.4(a)(9)(vii) and 199.15)

1. Provisions of Proposed Rule

Revisions to section 199.4(a)(9) would provide the basis for administrative linkages between a determination of medical necessity and the decision to issue or deny an Nonavailability Statement (NAS). NAS's are issued when an MTF lacks the capacity or capability to provide a service, but carry no imprimatur of medical necessity. Proposed revisions to section 199.15 establish ground rules for CHAMPUS PRO review of care in MTFs, and would allow for consolidated determinations of medical necessity applicable to both the

MTF and civilian contexts when the CHAMPUS PRO performs the review.

2. Public Comments

One commenter suggested that the provisions for integration of CHAMPUS Peer Review Organization and military utilization review activities are unclear. Also, the commenter indicated that the provisions allowing separate determinations of medical necessity by the MTF and CHAMPUS, with the military decision not binding on CHAMPUS would place the provider and beneficiary at risk.

Response. We disagree that separate decisions of medical necessity place beneficiaries and providers at risk in this context. We believe just the opposite is true. The rule simply provides that if an MTF reserves authority to make its own determinations on medical necessity, which it might do for reasons relating to management and operation of that particular facility, those determinations are not binding on CHAMPUS. The CHAMPUS system has a well-established decision-making structure, complete with numerous procedural requirements and appeal mechanisms. The preservation of the functioning of this structure protects the interests of beneficiaries and providers.

3. Provisions of the Final Rule

The final rule is consistent with the proposed rule.

V. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any ''economically significant regulatory action,'' defined as one which would result in an annual effect on the economy of $100 million or more, or have other substantial impacts.

This is not an economically significant regulatory action under the provisions of Executive Order 12866; however, OMB has reviewed this rule as significant under other provisions of the Executive Order. One commenter on the proposed rule questioned this assessment, since the imposition of enrollment fees on many retirees would have an economically significant impact. We point out that, while the cost sharing structure of TRICARE Prime is changed significantly from standard CHAMPUS cost sharing, the overall effects on beneficiary out-of-pocket costs are relatively minor. For retirees, their family members and survivors, TRICARE Prime enrollment fees in essence replace the deductibles and high inpatient care cost sharing under standard CHAMPUS. The mix of cost sharing requirements in TRICARE Prime is expected to produce aggregate annual out-of-pocket cost reductions for these beneficiaries of about $100 per person, compared to what would be expected absent the program.

The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. The Department of Defense has certified that this regulatory action would not have a significant impact on a substantial number of small entities.

This rule will impose additional information collection requirements on the public, associated with beneficiary enrollment, under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3511). Information collection requirements have been forwarded to OMB for review. The collection instrument serves as an application form for enrollment in TRICARE Prime. The information is needed to indicate beneficiary agreement to abide by the rules of the program and to obtain necessary information to process the beneficiary's request to enroll in TRICARE Prime. The third party administrator chosen to manage the enrollment program, which will be the managed care support contractor in each region, will make enrollment applications available to those who wish to enroll in Prime. The following information is included in the information requirements that have been forwarded to OMB for review:

Number of Respondents: 300,000.

Responses Per Respondent: 1.

Annual Responses: 300,000.

Average Burden Per Response: 15 Minutes.

Annual Burden Hours: 75,000.

Other information collected includes necessary data to determine beneficiary eligibility, other health insurance liability, premium payment, and to identify selection of health care provider.

TABLE 1.—CONSOLIDATED SCHEDULE OF BENEFICIARY CHARGES

	TRICARE prime	TRICARE standard	Medicare eligible beneficiaries
Services from TRICARE Network Providers.	Uniform HMO Benefit cost sharing applies (see Table 3), except unauthorized care covered by point-of-service rules.	TRICARE Extra cost sharing applies (see Table 2).	Cost sharing for Medicare participating providers applies.
Services from non-network providers.	TRICARE Prime point-of-service rules apply: deductible of $300 per person or $600 per family; cost share of 50 percent.	Standard CHAMPUS cost sharing applies.	Standard Medicare cost sharing applies.
Internal resource sharing agreements.	Same as military facility cost sharing.	Same as military facility cost sharing.	Where applicable, same as military facility cost sharing.
External resource sharing agreements.	For professional charges, same as military facility cost sharing; for facility charges, same as Uniform HMO Benefit cost sharing.	For professional charges, same as military facility cost sharing; for facility charges, same as TRICARE Extra cost sharing.	Where applicable, for professional charges, same as military facility cost sharing; for facility charges, same as standard Medicare cost sharing.
PRIMUS and NAVCARE Clinics ...	Same as military facilities	Same as military facilities	Same as military facilities.

TABLE 1.—CONSOLIDATED SCHEDULE OF BENEFICIARY CHARGES—Continued

	TRICARE prime	TRICARE standard	Medicare eligible beneficiaries
Prescription drugs from civilian pharmacies.	As specified in Uniform HMO Benefit (see Table 3); for mail service pharmacy, $4 per prescription for active duty dependents; $8 per prescription for retirees, their dependents and survivors.	For retail pharmacy network, TRICARE Extra Cost sharing applies; for mail service pharmacy, $4 per prescription for active duty dependents; $8 per prescription for retirees, their dependents and survivors; for other civilian pharmacies, standard CHAMPUS cost sharing applies.	In facility closure cases: from retail pharmacy network, 20 percent cost share; from mail service pharmacy, $8 per prescription; no deductible.
Outpatient services in military facilities.	No charge	Same as TRICARE Prime	Same as TRICARE Prime.
Inpatient services in military facilities.	Applicable daily subsistence charges.	Same as TRICARE Prime	Same as TRICARE Prime.

TABLE 2.—TRICARE TRIPLE OPTION PROGRAM

	TRICARE standard	TRICARE extra	TRICARE prime
Enrollment fee	None	None	ACT DUTY DEPS—None others—$230; individual, $460 family.
Outpatient deductible	$300 Family ($100 E4 & below)	Same as standard CHAMPUS	None.
Outpatient services cost shares, including mental health, emergency services, etc.	ACT DUTY DEPS—20% copay after deductible; others—25% copay after deductible.	ACT DUTY DEPS—15% copay after deductible; others—20% copay after deductible.	See Table 3—Schedule of Uniform HMO Benefit Copayments.
Inpatient cost shares, including maternity and skilled nursing facilities, not including mental health.	ACT DUTY DEPS—$25 Per admission or current per diem, whichever is greater; others—Lesser of applicable per diem ($323 in FY 1995) or 25% of institutional billed charges, plus 25% of professional charges.	ACT DUTY DEPS—Same as Standard CHAMPUS; others—lesser of $250 per day or 25% of institutional billed charges, plus 20% of professional charges.	See Table 3—Schedule of Uniform HMO Benefit Copayments.
Ambulatory Surgery	ACT DUTY DEPS—$25 per episode; others—25% of allowable charges.	ACT DUTY DEPS—$25 copay; others—20% copay after deductible.	See Table 3—Schedule of Uniform HMO Benefit Copayments.
Prescription drug benefits	ACT DUTY DEPS—20% cost share after deductible others—25% cost share after deductible. For mail service pharmacy, $4 per prescription for active duty dependents; $8 per prescription for retirees, their dependents and survivors.	ACT DUTY DEPS—15% cost share; no deductible; others—20% cost share; no deductible. For mail service pharmacy, $4 per prescription for active duty dependents; $8 per prescription for retirees, their dependents and survivors.	ACT DUTY DEPS—$5 per prescription; others—$9 per prescription. For mail service pharmacy, $4 per prescription for active duty dependents; $8 per prescription for retirees, their dependents and survivors.
Hospitalization for mental illness and substance use.	ACT DUTY DEPS—$25 per admission or $20 per diem whichever is greater; others—lesser of applicable per diem ($132 in FY 1995) or 25% of institutional charges, plus 25% of professional charges.	ACT DUTY DEPS—Same as TRICARE Standard; others—20% of institutional and professional charges.	ACT DUTY DEPS—Same as TRICARE Standard; others—$40 per diem.

Note: This chart is for illustrative purposes only. It does not include all details of benefits and copayments.

TABLE 3.—UNIFORM HMO BENEFIT FEE AND COPAYMENT SCHEDULE

	ADDs E4 and below	ADDs E5 and above	Retirees, deps, and survivors
Annual Enrollment Fee	$0/$0	$0/$0	$230/$460.
Outpatient Visits, Including Separate Radiology or Lab Services, Family Health, and Home Health Visits.	$6	$12	$12.
Emergency Room Visits	$10	$30	$30.
Mental Health Visits, Individual	$10	$20	$25.
Mental Health Visits, Group	$6	$12	$17.
Ambulatory Surgery	$25	$25	$25.
Prescriptions	$5	$5	$9.
Ambulance Services	$10	$15	$20.
DME, Prostheses, Supplies	10 percent	15 percent	20 percent.
Inpatient Per Diem, General	$11, minimum $25 per admission.	$11, minimum $25 per admission.	$11, minimum $25 per admission.

TABLE 3.—UNIFORM HMO BENEFIT FEE AND COPAYMENT SCHEDULE—Continued

	ADDs E4 and below	ADDs E5 and above	Retirees, deps, and survivors
Inpatient Per Diem, MH/Substance Use	$20, minimum $25 per admission.	$20, minimum $25 per admission.	$40.
Catastrophic Cap on Out-of-Pocket Costs related to Allowable Charges.	$1,000	$1,000	$3,000.

List of Subjects in 32 CFR Part 199

Claims, handicapped, health insurance, and military personnel.

Accordingly, 32 CFR part 199 is amended as follows:

PART 199—[AMENDED]

1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

2. Section 199.1 is amended by adding a new paragraph (r) to read as follows:

§ 199.1 General provisions.

* * * * *

(r) *TRICARE program*. Many rules and procedures established in sections of this part are subject to revision in areas where the TRICARE program is implemented. The TRICARE program is the means by which managed care activities designed to improve the delivery and financing of health care services in the Military Health Services System(MHSS) are carried out. Rules and procedures for the TRICARE program are set forth in § 199.17.

3. Section 199.2(b) is amended by adding the following definitions and placing them in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

External resource sharing agreement. A type External Partnership Agreement, established in the context of the TRICARE program by agreement of a military medical treatment facility commander and an authorized TRICARE contractor. External Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard External Partnership Agreements.

* * * * *

Internal resource sharing agreement. A type of Internal Partnership Agreement, established in the context of the TRICARE program by agreement of a military medical treatment facility commander and authorized TRICARE contractor. Internal Resource Sharing Agreements may incorporate TRICARE features in lieu of standard CHAMPUS features that would apply to standard Internal Partnership Agreements.

* * * * *

NAVCARE clinics. Contractor owned, staffed, and operated primary clinics exclusively serving uniformed services beneficiaries pursuant to contracts awarded by a Military Department.

* * * * *

PRIMUS clinics. Contractor owned, staffed, and operated primary care clinics exclusively serving uniformed services beneficiaries pursuant to contracts awarded by a Military Department.

* * * * *

TRICARE extra plan. The health care option, provided as part of the TRICARE program under § 199.17, under which beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost sharing), or from any other CHAMPUS-authorized provider (with standard cost sharing).

TRICARE prime plan. The health care option, provided as part of the TRICARE program under § 199.17, under which beneficiaries enroll to receive all health care from facilities of the uniformed services and civilian network providers (with civilian care subject to substantially reduced cost sharing.

TRICARE program. The program establish under § 199.17.

TRICARE standard plan. The health care option, provided as part of the TRICARE program under § 199.17, under which beneficiaries are eligible for care in facilities of the uniformed services and CHAMPUS under standard rules and procedures.

Uniform HMO benefit. The health care benefit established by § 199.18.

* * * * *

4. Section 199.4 is amended by redesignating paragraph (a)(1) as paragraph (a)(1)(i), by revising paragraph (a)(9)(i)(C), by adding new paragraph (a)(1)(ii), and by adding new paragraph (a)(9)(vi) before the note to read as follows:

§ 199.4 Basic program benefits.

(a) * * *

(1) * * *

(ii) *Impact of TRICARE program*. The basic program benefits set forth in this section are applicable to the basic CHAMPUS program. In areas in which the TRICARE program is implemented, certain provisions of § 199.17 will apply instead of the provisions of this section. In those areas, the provisions of § 199.17 will take precedence over any provisions of this section with which they conflict.

* * * * *

(9) * * *

(i) * * *

(C) An NAS is also required for selected outpatient procedures if such services are not available at a Uniformed Service facility (including selected facilities which are exclusively outpatient clinics) located within a 40-mile radius (catchment area) of the residence of the beneficiary. This does not apply to emergency services or for services for which another insurance plan or program provides the beneficiary primary coverage. Any changes to the selected outpatient procedures will be published by the Assistance Secretary of Defense (Health Affairs) in the Federal Register at least 30 days before the effective date of the change and will be limited to the following categories: Outpatient surgery and other selected outpatient procedures which have high unit costs and for which care may be available in military facilities generally. The selected outpatient procedures will be uniform for all CHAMPUS beneficiaries. A list of the selected outpatient clinics to which this NAS requirement applies will be published periodically in the Federal Register.

* * * * *

(vi) In the case of any service subject to an NAS requirement under paragraph (a)(9) of this section and also subject to a preadmission (or other pre-service) authorization requirement under § 199.4 or § 199.15, the administrative processes for the NAS and pre-service authorization may be combined.

* * * * *

§ 199.14 [Amended]

5. Section 199.14 is amended by removing paragraph (h)(1)(i)(C) and by

redesignating paragraph (h)(1)(i)(D) as paragraph (h)(1)(i)(C).

6. Section 199.15 is amended by adding a new paragraph (n) to read as follows:

§ 199.15 Quality and utilization review peer review organization program.

* * * * *

(n) *Authority to integrate CHAMPUS PRO and military medical treatment facility utilization review activities.*

(1) In the case of a military medical treatment facility (MTF) that has established utilization review requirements similar to those under the CHAMPUS PRO program, the contractor carrying out this function may, at the request of the MTF, utilize procedures comparable to the CHAMPUS PRO program procedures to render determinations or recommendations with respect to utilization review requirements.

(2) In any case in which such a contractor has comparable responsibility and authority regarding utilization review in both an MTF (or MTFs) and CHAMPUS, determinations as to medical necessity in connection with services from an MTF or CHAMPUS-authorized provider may be consolidated.

(3) In any case in which an MTF reserves authority to separate an MTF determination on medical necessity from a CHAMPUS PRO program determination on medical necessity, the MTF determination is not binding on CHAMPUS.

7. Section 199.17 amd 199.18 are added to read as follows:

§ 199.17 TRICARE program.

(a) *Establishment.* The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the MHSS.

(1) *Purpose.* The TRICARE program implements management improvements primarily through managed care support contracts that include special arrangements with civilian sector health care providers and better coordination between military medical treatment facilities (MTFs) and these civilian providers. Implementation of these management improvements includes adoption of special rules and procedures not ordinarily followed under CHAMPUS or MTF requirements. This section establishes those special rules and procedures.

(2) *Statutory authority.* Many of the provisions of this section are authorized by statutory authorities other than those which authorize the usual operation of the CHAMPUS program, especially 10 U.S.C. 1079 and 1086. The TRICARE program also relies upon other available statutory authorities, including 10 U.S.C. 1099 (health care enrollment system), 10 U.S.C. 1097 (contracts for medical care for retirees, dependents and survivors: alternative delivery of health care), and 10 U.S.C. 1096 (resource sharing agreements).

(3) *Scope of the program.* The TRICARE program is applicable to all of the uniformed services. Its geographical applicability is all 50 states and the District of Columbia, In addition, if authorized by the Assistant Secretary of Defense (Health Affairs), the TRICARE program may be implemented in areas outside the 50 states and the District of Columbia. In such cases, the Assistant Secretary of Defense (Health Affairs) may also authorize modifications to TRICARE program rules and procedures as may be appropriate to the area involved.

(4) *MTF rules and procedures affected.* Much of this section relates to rules and procedures applicable to the delivery and financing of health care services provided by civilian providers outside military treatment facilities. This section provides that certain rules, procedures, rights and obligations set forth elsewhere in this part (and usually applicable to CHAMPUS) are different under the TRICARE program. In addition, some rules, procedures, rights and obligations relating to health care services in military treatment facilities are also different under the TRICARE program. In such cases, provisions of this section take precedence and are binding.

(5) *Implementation based on local action.* The TRICARE program is not automatically implemented in all areas where it is potentially applicable. Therefore, provisions of this section are not automatically implemented, Rather, implementation of the TRICARE program and this section requires an official action by an authorized individual, such as a military medical treatment facility commander, a Surgeon General, the Assistant Secretary of Defense (Health Affairs), or other person authorized by the Assistant Secretary. Public notice of the initiation of the TRICARE program will be achieved through appropriate communication and media methods and by way of an official announcement by the Director, OCHAMPUS, identifying the military medical treatment facility catchment area or other geographical area covered.

(6) *Major features of the TRICARE program.* The major features of the TRICARE program, described in this section, include the following:

(i) *Comprehensive enrollment system.* Under the TRICARE program, all health care beneficiaries become classified into one of five enrollment categories:

(A) Active duty members, all of whom are automatically enrolled in TRICARE Prime;

(B) TRICARE Prime enrollees, who (except for active duty members) must be CHAMPUS eligible;

(C) TRICARE Standard eligible beneficiaries, which covers all CHAMPUS-eligible beneficiaries who do not enroll in TRICARE Prime or another managed care program affiliated with TRICARE;

(D) Medicare-eligible beneficiaries, who, although not eligible for TRICARE Prime, may participate in many features of TRICARE; and

(E) Participants in other managed care program affiliated with TRICARE (when such affiliation arrangements are made).

(ii) *Establishment of a triple option benefit.* A second major feature of TRICARE is the establishment for CHAMPUS-eligible beneficiaries of three options for receiving health care:

(A) Beneficiaries may enroll in the ''TRICARE Prime Plan,'' which features use of military treatment facilities and substantially reduced out-of-pocket costs for CHAMPUS care. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks, in accordance with enrollment provisions.

(B) Beneficiaries may participate in the ''TRICARE Extra Plan'' under which the preferred provider network may be used on a case-by-case basis, with somewhat reduced out-of-pocket costs. These beneficiaries also continue to be eligible for military medical treatment facility care on a space-available basis.

(C) Beneficiaries may remain in the ''TRICARE Standard Plan,'' which preserves broad freedom of choice of civilian providers (subject to nonavailability statement requirements of § 199.4), but does not offer reduced out-of-pocket costs. These beneficiaries continue to be eligible to receive care in military medical treatment facilities on a space-available basis.

(iii) *Coordination between military and civilian health care delivery systems.* A third major feature of the TRICARE program is a series of activities affecting all beneficiary enrollment categories, designed to coordinate care between military and civilian health care systems. These activities include:

(A) Resource sharing agreements, under which a TRICARE contractor provides to a military medical treatment

facility, personnel and other resources to increase the availability of services in the facility. All beneficiary enrollment categories may benefit from this increase.

(B) Health care finder, an administrative activity that facilitates referrals to appropriate health care services in the military facility and civilian provider network. All beneficiary enrollment categories may use the health care finder.

(C) Integrated quality and utilization management services, potentially standardizing reviews for military and civilian sector providers. All beneficiary categories may benefit from these services.

(D) Special pharmacy programs for areas affected by base realignment and closure actions. This includes special eligibility for Medicare-eligible beneficiaries.

(iv) *Consolidated schedule of charges.* A fourth major feature of TRICARE is a consolidated schedule of charges, incorporating revisions that reduce differences in charges between military and civilian services. In general, the TRICARE program reduces out-of-pocket costs for civilian sector care.

(b) *Triple option benefit in general.* Where the TRICARE program is implemented, CHAMPUS-eligible beneficiaries are given the options of enrolling in the TRICARE Prime Plan (also referred to as ''Prime''); being a participant in TRICARE Extra on a case-by-case basis (also referred to as ''Extra''); or remaining in the TRICARE Standard Plan (also referred to as ''Standard'').

(1) *Choice voluntary.* With the exception of active duty members, the choice of whether to enroll in Prime, to participate in Extra, or to remain in Standard is voluntary for all eligible beneficiaries. This applies to active duty dependents and eligible retired members, dependents of retired members, and survivors. For dependents who are minors, the choice will be exercised by a parent or guardian.

(2) *Active duty members.* For active duty members located in areas where the TRICARE program is implemented, enrollment in Prime is mandatory.

(c) *Eligibility for enrollment in Prime.* Where the TRICARE program is implemented, all CHAMPUS- eligible beneficiaries are eligible to enroll. However, some rules and procedures are different for dependents of active duty members than they are for retirees, their dependents and survivors. In addition, where the TRICARE program is implemented, a military medical treatment facility commander or other authorized individual may establish priorities, consistent with paragraph (c) of this section, based on availability or other operational requirements, for when and whether to offer the enrollment opportunity.

(1) *Active duty members.* Active duty members are required to enroll in Prime when it is offered. Active duty members shall have first priority for enrollment in Prime. Because active duty members are not CHAMPUS eligible, when active duty members obtain care from civilian providers outside the military medical treatment facility, the supplemental care program and its requirements (including § 199.16) will apply.

(2) *Dependents of active duty members.* (i) Dependents of active duty members are eligible to enroll in Prime. After all active duty members, dependents of active duty members will have second priority for enrollment.

(ii) If all dependents of active duty members within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may establish priorities within this beneficiary group category. The priorities may be based on first-come, first-served, or alternatively, be based on rank of sponsor, beginning with the lowest pay grade.

(3) *Retired member, dependents of retired members, and survivors.* (i) All CHAMPUS-eligible retired members, dependents of retired members, and survivors are eligible to enroll in Prime. After all active duty members are enrolled and availability of enrollment is assured for all active duty dependents wishing to enroll, this category of beneficiaries will have third priority for enrollment.

(ii) If all CHAMPUS-eligible retired members, dependents of retired members, and survivors within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may allow enrollment within this beneficiary group category on a first come, first served basis.

(4) *Participation in extra and standard.* All CHAMPUS-eligible beneficiaries who do not enroll in Prime may participate in Extra on a case-by-case basis or remain in Standard.

(d) *Health benefits under Prime.* Health benefits under Prime, set forth in paragraph (d) of this section, differ from those under Extra and Standard, set forth in paragraphs (e) and (f) of this section.

(1) *Military treatment facility (MTF) care.* All participants in Prime are eligible to receive care in military treatment facilities. Active duty dependents who are participants in Prime will be given priority for such care over active duty dependents who declined the opportunity to enroll in Prime. The latter group, however, retains priority over retirees, their dependents and survivors. There is no priority for MTF care among retirees, their dependents and survivors based on enrollment status.

(2) *Non-MTF care for active duty members.* Under Prime, non-MTF care needed by active duty members continues to be arranged under the supplemental care program and subject to the rules and procedures of that program, including those set forth in § 199.16.

(3) *Benefits covered for CHAMPUS eligible beneficiaries for civilian sector care.* The provisions of § 199.18 regarding the Uniform HMO Benefit apply to TRICARE Prime enrollees.

(e) *Health benefits under the TRICARE extra plan.* Beneficiaries not enrolled in Prime, although not in general required to use the Prime civilian preferred provider network, are eligible to use the network on a case-by-case basis under Extra. The health benefits under Extra are identical to those under Standard, set forth in paragraph (f) of this section, except that the CHAMPUS cost sharing percentages are lower than usual CHAMPUS cost sharing. The lower requirements are set forth in the consolidated schedule of charges in paragraph (m) of this section.

(f) *Health benefits under the TRICARE standard plan.* Where the TRICARE program is implemented, health benefits under Prime, set forth under paragraph (d) of this section, and Extra, set forth under paragraph (e) of this section, are different than health benefits under Standard, set forth in this paragraph (f).

(1) *Military treatment facility (MTF) care.* All nonenrollees (including beneficiaries not eligible to enroll) continue to be eligible to receive care in military treatment facilities on a space available basis.

(a) *Freedom of choice of civilian provider.* Except as stated in § 199.4(a) in connection with nonavailability statement requirements, CHAMPUS-eligible participants in Standard maintain their freedom of choice of civilian provider under CHAMPUS. All nonavailability statement requirements of § 199.4(a) apply to Standard participants.

(3) *CHAMPUS benefits apply.* The benefits, rules and procedures of the CHAMPUS basis program as set forth in this part, shall apply to CHAMPUS-eligible participants in Standard.

(4) *Preferred provider network option for standard participants.* Standard participants, although not generally required to use the TRICARE program preferred provider network are eligible to use the network on a case-by-case basis, under Extra.

(g) *Coordination with other health care programs.* [Reserved.]

(h) *Resource sharing agreements.* Under the TRICARE program, any military medical treatment facility (MTF) commander may establish resource sharing agreements with the applicable managed care support contractor for the purpose of providing for the sharing of resources between the two parties. Internal resource sharing and external resource sharing agreements are authorized. The provisions of this paragraph (h) shall apply to resource sharing agreements under the TRICARE program.

(1) In connection with internal resource sharing agreements, beneficiary cost sharing requirements shall be the same as those applicable to health care services provided in facilities of the uniformed services.

(2) Under internal resource sharing agreements, the double coverage requirements of § 199.8 shall be replaced by the Third Party Collection procedures of 32 CFR part 220, to the extent permissible under such Part. In such a case, payments made to a resource sharing agreement provider through the TRICARE managed care support contractor shall be deemed to be payments by the MTF concerned.

(3) Under internal or external resource sharing agreements, the commander of the MTF concerned may authorize the provision of services, pursuant to the agreement, to Medicare-eligible beneficiaries, if such services are not reimbursable by Medicare, and if the commander determines that this will promote the most cost-effective provision of services under the TRICARE program.

(i) *Health care finder.* The Health Care Finder is an administrative activity that assists beneficiaries in being referred to appropriate health care providers, especially the MTF and preferred providers. Health Care Finder services are available to all beneficiaries. In the case of TRICARE Prime enrollees, the Health Care Finder will facilitate referrals in accordance with Prime rules and procedures. For Standard participants, the Finder will provide assistance for use of Extra. For Medicare-eligible beneficiaries, the Finder will facilitate referrals to TRICARE network providers, generally required to be Medicare participating providers. For participants in other managed care programs, the Finder will assist in referrals pursuant to the arrangements made with the other managed care program. For all beneficiary enrollment categories, the finder will assist in obtaining access to available services in the medical treatment facility.

(j) *General quality assurance, utilization review, and preauthorization requirements under TRICARE program.* All quality assurance, utilization review, and preauthorization requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of §§ 199.4 and 199.15), are applicable to Prime, Extra and Standard under the TRICARE program. Under all three options, some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE program has not been implemented. Pursuant to an agreement between a military medical treatment facility and TRICARE managed care support contractor, quality assurance, utilization review, and preauthorization requirements and procedures applicable to health care services outside the military medical treatment facility may be made applicable, in whole or in part, to health care services inside the military medical treatment facility.

(k) *Pharmacy services, including special services in base realignment and closure sites.*

(1) *In general.* TRICARE includes two special programs under which covered beneficiaries, including Medicare-eligible beneficiaries, who live in areas adversely affected by base realignment and closure actions are given a pharmacy benefit for prescription drugs provided outside military treatment facilities. The two special programs are the retail pharmacy network program and the mail service pharmacy program.

(2) *Retail pharmacy network program.* To the maximum extent practicable, a retail pharmacy network program will be included in the TRICARE program wherever implemented. Except for the special rules applicable to Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures, the retail pharmacy network program will function in accordance with TRICARE rules and procedures otherwise applicable. In addition, a retail pharmacy network program may, on a temporary, transitional basis, be established in a base realignment or closure site independent of other features of the TRICARE program. Such a program may be established through arrangements with one or more pharmacies in the area and may continue until a managed care program is established to serve the affected beneficiaries.

(3) *Mail service pharmacy program.* A mail service pharmacy program will be established to the extent required by law as part of the TRICARE program. The special rules applicable to Medicare-eligible beneficiaries established in this paragraph (k) shall be applicable.

(4) *Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures.* Under the retail pharmacy network program and mail service pharmacy program, there is a special eligibility rule pertaining to Medicare-eligible beneficiaries in areas adversely affected by military medical treatment facility closures.

(i) *Medicare-eligible beneficiaries.* The special eligibility rule pertains to military system beneficiaries who are not eligible for CHAMPUS solely because of their eligibility for part A of Medicare.

(ii) *Area adversely affected by closure.* To be eligible for use of the retail pharmacy network program or mail service pharmacy program based on residency, a Medicare-eligible beneficiary must maintain a principal place of residency in the catchment area of the MTF that closed. In addition, there must be a retail pharmacy network or mail service pharmacy established in that area. In identifying areas adversely affected by a closure, the provisions of this paragraph (k)(4)(ii) shall apply.

(A) In the case of the closure of a military hospital, the area adversely affected is the established 40-mile catchment area of the military hospital that closed.

(B) In the case of the closure of a military clinic (a military medical treatment facility that provided no inpatient care services), the area adversely affected is an area approximately 40 miles in radius from the clinic, established in a manner comparable to the manner in which catchment areas of military hospitals are established. However, this area will not be considered adversely affected by the closure of the clinic if the Director, OCHAMPUS determines that the clinic was not, when it had been in regular operation, providing a substantial amount of pharmacy services to retirees, their dependents, and survivors.

(iii) *Other Medicare-eligible beneficiaries adversely affected.* In addition to beneficiaries identified in paragraph (k)(4)(ii) of this section, eligibility for the retail pharmacy network program and mail service

pharmacy program is also established for any Medicare-eligible beneficiary who can demonstrate to the satisfaction of the Director, OCHAMPUS, that he or she relied upon an MTF that closed for his or her pharmaceuticals. Medicare beneficiaries who obtained pharmacy services at the facility that closed within the 12-month period prior to its closure will be deemed to be reliant on the facility. Validation that any such beneficiary obtained such services may be provided through records of the facility or by a written declaration of the beneficiary. Beneficiaries providing such a declaration are required to provide correct information. Intentionally providing false information or otherwise failing to satisfy this obligation is grounds for disqualification for health care services from facilities of the uniformed services and mandatory reimbursement for the cost of any pharmaceuticals provided based on the improper declaration.

(iv) *Effective date of eligibility for Medicare-eligible beneficiaries.* In any case in which, prior to the complete closure of a military medical treatment facility which is in the process of closure, the Director, OCHAMPUS, determines that the area has been adversely affected by severe reductions in access to services, the Director, OCHAMPUS may establish an effective date for eligibility for the retail pharmacy network program or mail service pharmacy program for Medicare-eligible beneficiaries prior to the complete closure of the facility.

(5) *Effect of other health insurance.* The double coverage rules of § 199.8 are applicable to services provided to all beneficiaries under the retail pharmacy network program or mail service pharmacy program. For this purpose, to the extent they provide a prescription drug benefit, Medicare supplemental insurance plans or Medicare HMO plans are double coverage plans and will be the primary payor.

(6) *Procedures.* The Director, OCHAMPUS shall establish procedures for the effective operation of the retail pharmacy network program and mail service pharmacy program. Such procedures may include the use of appropriate drug formularies, restrictions of the quantity of pharmaceuticals to be dispensed, encouragement of the use of generic drugs, implementation of quality assurance and utilization management activities, and other appropriate matters.

(l) *PRIMUS and NAVCARE clinics.*

(1) *Description and authority.* PRIMUS and NAVCARE clinics are contractor owned, staffed, and operated clinics that exclusively serve uniformed services beneficiaries. They are authorized as transitional entities during the phase-in of TRICARE. This authority to operate a PRIMUS or NAVCARE clinic will cease upon implementation of TRICARE in the clinic's location, or on October 1, 1997, whichever is later.

(2) *Eligible beneficiaries.* All TRICARE beneficiary categories are eligible for care in PRIMUS and NAVCARE Clinics. This includes active duty members, Medicare-eligible beneficiaries and other MHSS-eligible persons not eligible for CHAMPUS.

(3) *Services and charges.* For care provided PRIMUS and NAVCARE Clinics, CHAMPUS rules regarding program benefits, deductibles and cost sharing requirements do not apply. Services offered and charges will be based on those applicable to care provided in military medical treatment facilities.

(4) *Priority access.* Access to care in PRIMUS and NAVCARE Clinics shall be based on the same order of priority as is established for military treatment facilities care under paragraph (d)(1) of this section.

(m) *Consolidated schedule of beneficiary charges.* The following consolidated schedule of beneficiary charges is applicable to health care services provided under TRICARE for Prime enrollees, Standard enrollees and Medicare-eligible beneficiaries. (There are no charges to active duty members. Charges for participants in other managed health care programs affiliated with TRICARE will be specified in the applicable affiliation agreements.)

(1) *Cost sharing for services from TRICARE network providers.*

(i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit in § 199.18, except that for care not authorized by the primary care manager or Health Care Finder, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. For such unauthorized care, the deductible is $300 per person and $600 per family. The beneficiary cost share is 50 percent of the allowable charges for inpatient and outpatient care, after the deductible.

(ii) For Standard enrollees, TRICARE Extra cost sharing applies. The deductible is the same as standard CHAMPUS. Cost shares are as follows:

(A) For outpatient professional services, cost sharing will be reduced from 20 percent to 15 percent for dependents of active duty members.

(B) For most services for retired members, dependents of retired members, and survivors, cost sharing is reduced from 25 percent to 20 percent.

(C) In fiscal year 1996, the per diem inpatient hospital copayment for retirees, dependents of retirees, and survivors when they use a preferred provider network hospital is $250 per day, or 25 percent of total charges, whichever is less. There is a nominal copayment for active duty dependents, which is the same as under the CHAMPUS program (see § 199.4). The per diem amount may be updated for subsequent years based on changes in the standard CHAMPUS per diem.

(iii) For Medicare-eligible beneficiaries, cost sharing will generally be as applicable to Medicare participating providers.

(2) *Cost sharing for non-network providers.*

(i) For TRICARE Prime enrollees, rules applicable to the TRICARE point of service option (see paragraph (n)(3) of this section) are applicable. The deductible is $300 per person and $600 per family. The beneficiary cost share is 50 percent of the allowable charges, after the deductible.

(ii) For Standard enrollees, cost sharing is as specified for the basic CHAMPUS program.

(iii) For Medicare eligible beneficiaries, cost sharing is as provided under the Medicare program.

(3) *Cost sharing under internal resource sharing agreements.*

(i) For Prime enrollees, cost sharing is as provided in military treatment facilities.

(ii) For Standard enrollees, cost sharing is as provided in military treatment facilities.

(iii) For Medicare eligible beneficiaries, where made applicable by the commander of the *military medical treatment facility* concerned, cost sharing will be as provided in military treatment facilities.

(4) *Cost sharing under external resource sharing.*

(i) For Prime enrollees, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to institutional and related ancillary charges shall be as applicable to services provided under TRICARE Prime.

(ii) For TRICARE Standard participants, cost sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to non-military providers, including institutional and related ancillary charges, shall be as applicable to services provided under TRICARE Extra.

(iii) For Medicare-eligible beneficiaries, where available, cost

sharing applicable to services provided by military facility personnel shall be as applicable to services in military treatment facilities; that applicable to non-military providers, including institutional and related ancillary charges shall be as applicable to services provided under Medicare.

(5) *Prescription drugs.*

(i) For Prime enrollees, cost sharing is as specified in the Uniform HMO Benefit, except that the copayment under the mail service pharmacy program is $4.00 for active duty dependents and $8.00 for all other covered beneficiaries, per prescription, for up to a 90 day supply.

(ii) For Standard participants, there is a 15 percent cost share for active-duty dependents and a 20 percent cost share for retirees, their dependents and survivors for prescription drugs provided by retail pharmacy network providers; for prescription drugs obtained from network pharmacies, the CHAMPUS deductible will not apply. The copayment for all beneficiaries under the mail service pharmacy program is $4.00 for active duty dependents and $8.00 for all other covered beneficiaries, per prescription, for up to a 90 day supply. There is no deductible for this program.

(iii) For Medicare-eligible beneficiaries affected by military medical treatment facility closures, there is a 20 percent copayment for prescriptions provided under the retail pharmacy network program, and an $8.00 copayment per prescription, for up to a 90-day supply, for prescriptions provided by the mail service pharmacy program. There is no deductible under either program.

(6) *Cost share for outpatient services in military treatment facilities.*

(i) For dependents of active duty members in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(ii) For retirees, their dependents, and survivors in all enrollment categories, there is no charge for outpatient visits provided in military medical treatment facilities.

(n) *Additional health care management requirements under TRICARE prime.* Prime has additional, special health care management requirements not applicable under Extra, Standard or the CHAMPUS basic program. Such requirements must be approved by the Assistant Secretary of Defense (Health Affairs). In TRICARE, all care may be subject to review for medical necessity and appropriateness of level of care, regardless of whether the care is provided in a military medical treatment facility or in a civilian setting. Adverse determinations regarding care in military facilities will be appealable in accordance with established military medical department procedures, and adverse determinations regarding civilian care will be appealable in accordance with § 199.15.

(1) *Primary care manager.* All active duty members and Prime enrollees will be assigned or be allowed to select a primary care manager pursuant to a system established by the MTF Commander or other authorized official. The primary care manager may be an individual physician, a group practice, a clinic, a treatment site, or other designation. The primary care manager may be part of the MTF or the Prime civilian provider network. The enrollees will be given the opportunity to register a preference for primary care manager from a list of choices provided by the MTF Commander. Preference requests will be honored, subject to availability, under the MTF beneficiary category priority system and other operational requirements established by the commander (or other authorized person).

(2) *Restrictions on the use of providers.* The requirements of this paragraph (n)(2) shall be applicable to health care utilization under TRICARE Prime, except in cases of emergency care and under the point-of-service option (see paragraph (n)(3) of this section).

(i) Prime enrollees must obtain all primary health care from the primary care manager or from another provider to which the enrollee is referred by the primary care manager or an authorized Health Care Finder.

(ii) For any necessary specialty care and all inpatient care, the primary care manager or the Health Care Finder will assist in making an appropriate referral. All such nonemergency specialty care and inpatient care must be preauthorized by the primary care manager or the Health Care Finder.

(iii) The following procedures will apply to health care referrals and preauthorizations in catchment areas under TRICARE Prime:

(A) The first priority for referral for specialty care or inpatient care will be to the local MTF (or to any other MTF in which catchment area the enrollee resides).

(B) If the local MTF(s) are unavailable for the services needed, but there is another MTF at which the needed services can be provided, the enrollee may be required to obtain the services at that MTF. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the MTF involved for the service involved.

(C) If the needed services are available within civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a provider within the network. Subject to availability, the enrollee will have the freedom to choose a provider from among those in the network.

(D) If the needed services are not available within the civilian preferred provider network serving the area, the enrollee may be required to obtain the services from a designated civilian provider outside the area. However, this requirement will only apply to the extent that the enrollee was informed at the time of (or prior to) enrollment that mandatory referrals might be made to the provider involved for the service involved (with the provider and service either identified specifically or in connection with some appropriate classification).

(E) In cases in which the needed health care services cannot be provided pursuant to the procedures identified in paragraphs (n)(2)(iii) (A) through (D) of this section, the enrollee will receive authorization to obtain services from a CHAMPUS-authorized civilian provider(s) of the enrollee's choice not affiliated with the civilian preferred provider network.

(iv) When Prime is operating in noncatchment areas, the requirements in paragraphs (n)(2)(iii) (B) through (E) of this section shall apply.

(v) Any health care services obtained by a Prime enrollee, but not obtained in accordance with the utilization management rules and procedures of Prime will not be paid for under Prime rules, but may be covered by the point-of-service option (see paragraph (n)(3) of this section). However, Prime rules may cover such services if the enrollee did not know and could not reasonably have been expected to know that the services were not obtained in accordance with the utilization management rules and procedures of Prime.

(3) *Point-of-service option.* TRICARE Prime enrollees retain the freedom to obtain services from civilian providers on a point-of-service basis. In such cases, all requirements applicable to standard CHAMPUS shall apply, except that there shall be higher deductible and cost sharing requirements (as set forth in paragraphs (m)(1)(i) and (m)(2)(i) of this section).

(o) *TRICARE program enrollment procedures.* There are certain requirements pertaining to procedures for enrollment in Prime. (These procedures do not apply to active duty

members, whose enrollment is mandatory.)

(1) *Open Enrollment.* Beneficiaries will be offered the opportunity to enroll in Prime on a continuing basis.

(2) *Enrollment period.* The Prime enrollment period shall be 12 months. Enrollees must remain in Prime for a 12 month period, at which time they may disenroll. This requirement is subject to exceptions for change of residence and other changes announced at the time the TRICARE program is implemented in a particular area.

(3) *Quarterly installment payments of enrollment fee.* The enrollment fee required by § 199.18(c) may be paid in quarterly installments, each equal to one-fourth of the total amount, plus an additional maintenance fee of $5.00 per installment. For any beneficiary paying his or her enrollment fee in quarterly installments, failure to make a required installment payment on a timely basis (including a grace period, as determined by the Director, OCHAMPUS) will result in termination of the beneficiary's enrollment in Prime and disqualification from future enrollment in Prime for a period of one year.

(4) *Period revision.* Periodically, certain features, rules or procedures of Prime, Extra and/or Standard may be revised. If such revisions will have a significant effect on participants' costs or access to care, beneficiaries will be given the opportunity to change their enrollment status coincident with the revisions.

(5) *Effects of failure to enroll.* Beneficiaries offered the opportunity to enroll in Prime, who do not enroll, will remain in Standard and will be eligible to participate in Extra on a case-by-case basis.

(p) *Civilian preferred provider networks.* A major feature of the TRICARE program is the civilian preferred provider network.

(1) *Status of network providers.* Providers in the preferred provider network are not employees or agents of the Department of Defense or the United States Government. Rather, they are independent contractors of the government (or other independent entities having business arrangements with the government). Although network providers must follow numerous rules and procedures of the TRICARE program, on matters of professional judgment and professional practice, the network provider is independent and not operating under the direction and control of the Department of Defense. Each preferred provider must have adequate professional liability insurance, as required by the Federal Acquisition Regulation, and must agree to indemnify the United States Government for any liability that may be assessed against the United States Government that is attributable to any action or omission of the provider.

(2) *Utilization management policies.* Preferred providers are required to follow the utilization management policies and procedures of the TRICARE program. These policies and procedures are part of discretionary judgments by the Department of Defense regarding the methods of delivering and financing health care services that will best achieve health and economic policy objectives.

(3) *Quality assurance requirements.* A number of quality assurance requirements and procedures are applicable to preferred network providers. These are for the purpose of assuring that the health care services paid for with government funds meet the standards called for in the contract or provider agreement.

(4) *Provider qualifications.* All preferred providers must meet the following qualifications:

(i) They must be CHAMPUS authorized providers and CHAMPUS participating providers.

(ii) All physicians in the preferred provider network must have staff privileges in a hospital accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). This requirement may be waived in any case in which a physician's practice does not include the need for admitting privileges in such a hospital, or in locations where no JCAHO accredited facility exists. However, in any case in which the requirement is waived, the physician must comply with alternative qualification standards as are established by the MTF Commander (or other authorized official).

(iii) All preferred providers must agree to follow all quality assurance, utilization management, and patient referral procedures established pursuant to this section, to make available to designated DoD utilization management or quality monitoring contractors medical records and other pertinent records, and to authorize the release of information to MTF Commanders regarding such quality assurance and utilization management activities.

(iv) All preferred network providers must be Medicare participating providers, unless this requirement is waived based on extraordinary circumstances. This requirement that a provider be a Medicare participating provider does not apply to providers not eligible to be participating providers under Medicare.

(v) The provider must be available to Extra participants.

(vi) The provider must agree to accept the same payment rates negotiated for Prime enrollees for any person whose care is reimbursable by the Department of Defense, including, for example, Extra participants, supplemental care cases, and beneficiaries from outside the area.

(vii) All preferred providers must meet all other qualification requirements, and agree to comply with all other rules and procedures established for the preferred provider network.

(5) *Access standards.* Preferred provider networks will have attributes of size, composition, mix of providers and geographical distribution so that the networks, coupled with the MTF capabilities, can adequately address the health care needs of the enrollees. Before offering enrollment in Prime to a beneficiary group, the MTF Commander (or other authorized person) will assure that the capabilities of the MTF plus preferred provider network will meet the following access standards with respect to the needs of the expected number of enrollees from the beneficiary group being offered enrollment:

(i) Under normal circumstances, enrollee travel time may not exceed 30 minutes from home to primary care delivery site unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area.

(ii) The wait time for an appointment for a well-patient visit or a specialty care referral shall not exceed four weeks; for a routine visit, the wait time for an appointment shall not exceed one week; and for an urgent care visit the wait time for an appointment shall generally not exceed 24 hours.

(iii) Emergency services shall be available and accessible to handle emergencies (and urgent care visits if not available from other primary care providers pursuant to paragraph (p)(5)(ii) of this section), within the service area 24 hours a day, seven days a week.

(iv) The network shall include a sufficient number and mix of board certified specialists to meet reasonably the anticipated needs of enrollees. Travel time for specialty care shall not exceed one hour under normal circumstances, unless a longer time is necessary because of the absence of providers (including providers not part of the network) in the area. This requirement does not apply under the Specialized Treatment Services Program.

(v) Office waiting times in nonemergency circumstances shall not exceed 30 minutes, except when emergency care is being provided to patients, and the normal schedule is disrupted.

(6) *Special reimbursement methods for network providers.* The Director, OCHAMPUS, may establish, for preferred provider networks, reimbursement rates and methods different from those established pursuant to § 199.14. Such provisions may be expressed in terms of percentage discounts off CHAMPUS allowable amounts, or in other terms. In circumstances in which payments are based on hospital-specific rates (or other rates specific to particular institutional providers), special reimbursement methods may permit payments based on discounts off national or regional prevailing payment levels, even if higher than particular institution-specific payment rates.

(7) *Methods for establishing preferred provider networks.* There are several methods under which the MTF Commander (or other authorized official) may establish a preferred provider network. These include the following:

(i) There may be an acquisition under the Federal Acquisition Regulation, either conducted locally for that catchment area, in a larger area in concert with other MTF Commanders, regionally as part of a CHAMPUS acquisition, or on some other basis.

(ii) To the extent allowed by law, there may be a modification by the Director, OCHAMPUS, of an existing CHAMPUS fiscal intermediary contract to add TRICARE program functions to the existing responsibilities of the fiscal intermediary contractor.

(iii) The MTF Commander (or other authorized official) may follow the ''any qualified provider'' method set forth in paragraph (q) of this section.

(iv) Any other method authorized by law may be used.

(q) *Preferred provider network establishment under any qualified provider method.* The any qualified provider method may be used to establish a civilian preferred provider network. Under this method, any CHAMPUS-authorized provider within the geographical area involved that meets the qualification standards established by the MTF Commander (or other authorized official) may become a part of the preferred provider network. Such standards must be publicly announced and uniformly applied. Also under this method, any provider who meets all applicable qualification standards may not be excluded from the preferred provider network. Qualifications include:

(1) The provider must meet all applicable requirements in paragraph (p)(4) of this section.

(2) The provider must agree to follow all quality assurance and utilization management procedures established pursuant to this section.

(3) The provider must be a Participating Provider under CHAMPUS for all claims.

(4) The provider must meet all other qualification requirements, and agree to all other rules and procedures, that are established, publicly announced, and uniformly applied by the commander (or other authorized official).

(5) The provider must sign a preferred provider network agreement covering all applicable requirements. Such agreements will be for a duration of one year, are renewable, and may be canceled by the provider or the MTF Commander (or other authorized official) upon appropriate notice to the other party. The Director, OCHAMPUS shall establish an agreement model or other guidelines to promote uniformity in the agreements.

(r) *General fraud, abuse, and conflict of interest requirements under TRICARE program.* All fraud, abuse, and conflict of interest requirements for the basic CHAMPUS program, as set forth in this part 199 (see especially applicable provisions of § 199.9) are applicable to the TRICARE program. Some methods and procedures for implementing and enforcing these requirements may differ from the methods and procedures followed under the basic CHAMPUS program in areas in which the TRICARE program has not been implemented.

(s) *Partial implementation.* The Assistant Secretary of Defense (Health Affairs) may authorize the partial implementation of the TRICARE program. The following are examples of partial implementation:

(1) The TRICARE Extra Plan and the TRICARE Standard Plan may be offered without the TRICARE Prime Plan.

(2) In remote sites, where complete implementation of TRICARE is impracticable, TRICARE Prime may be offered to a limited group of beneficiaries. In such cases, normal requirements of TRICARE Prime which the Assistant Secretary of Defense (Health Affairs) determines are impracticable may be waived.

(3) The TRICARE program may be limited to particular services, such as mental health services.

(t) *Inclusion of Department of Veterans Affairs Medical Centers in TRICARE networks.* TRICARE preferred provider networks may include Department of Veterans Affairs health facilities pursuant to arrangements, made with the approval of the Assistant Secretary of Defense (Health Affairs), between those centers and the Director, OCHAMPUS, or designated TRICARE contractor.

(u) *Care provided outside the United States to dependents of active duty members.* The Assistant Secretary of Defense (Health Affairs) may, in conjunction with implementation of the TRICARE program, authorize a special CHAMPUS program for dependents of active duty members who accompany the members in their assignments in foreign countries. Under this special program, a preferred provider network will be established through contracts or agreements with selected health care providers. Under the network, CHAMPUS covered services will be provided to the covered dependents with all CHAMPUS requirements for deductibles and copayments waived. The use of this authority by the Assistant Secretary of Defense (Health Affairs) for any particular geographical area will be announced in the Federal Register. The announcement will include a description of the preferred provider network program and other pertinent information.

(v) *Administrative procedures.* The Assistant Secretary of Defense (Health Affairs), the Director, OCHAMPUS, and MTF Commanders (or other authorized officials) are authorized to establish administrative requirements and procedures, consistent with this section, this part, and other applicable DoD Directives or Instructions, for the implementation and operation of the TRICARE program.

§ 199.18 Uniform HMO Benefit.

(a) *In general.*

There is established a Uniform HMO Benefit. The purpose of the Uniform HMO benefit is to establish a health benefit option modeled on health maintenance organization plans. This benefit is intended to be uniform wherever offered throughout the United States and to be included in all managed care programs under the MHSS. Most care purchased from civilian health care providers (outside an MTF) will be under the rules of the Uniform HMO Benefit or the Basic CHAMPUS Program (see § 199.4). The Uniform HMO Benefit shall apply only as specified in this section or other sections of this part, and shall be subject to any special applications indicated in such other sections.

(b) *Services covered under the uniform HMO benefit option.*

(1) Except as specifically provided or authorized by this section, all CHAMPUS benefits provided, and benefit limitations established, pursuant to this part, shall apply to the Uniform HMO Benefit.

(2) Certain preventive care services not normally provided as part of basic program benefits under CHAMPUS are covered benefits when provided to Prime enrollees by providers in the civilian provider network. Standards for preventive care services shall be developed based on guidelines from the U.S. Department of Health and Human Services. Such standards shall establish a specific schedule, including frequency or age specifications for:

(i) Laboratory and x-ray tests, including blood lead, rubella, cholesterol, fecal occult blood testing, and mammography;

(ii) Pap smears;

(iii) Eye exams;

(iv) Immunizations;

(v) Periodic health promotion and disease prevention exams;

(vi) Blood pressure screening;

(vii) Hearing exams;

(viii) Sigmoidoscopy or colonoscopy;

(ix) Serologic screening; and

(x) Appropriate education and counseling services. The exact services offered shall be established under uniform standards established by the Assistant Secretary of Defense (Health Affairs).

(3) In addition to preventive care services provided pursuant to paragraph (b)(2) of this section, other benefit enhancements may be added and other benefit restrictions may be waived or relaxed in connection with health care services provided to include the Uniform HMO Benefit. Any such other enhancements or changes must be approved by the Assistant Secretary of Defense (Health Affairs) based on uniform standards.

(c) *Enrollment fee under the uniform HMO benefit.*

(1) The CHAMPUS annual deductible amount (see § 199.4(f)) is waived under the Uniform HMO Benefit during the period of enrollment. In lieu of a deductible amount, an annual enrollment fee is applicable. The specific enrollment fee requirements shall be published annually by the Assistant Secretary of Defense (Health Affairs), and shall be uniform within the following groups: dependents of active duty members in pay grades of E–4 and below; active duty dependents of sponsors in pay grades E–5 and above; and retirees and their dependents.

(2) *Amount of enrollment fees.* Beginning in fiscal year 1996, the annual enrollment fees are:

(i) for dependents of active duty members in pay grades of E–4 and below, $0;

(ii) for active duty dependents of sponsors in pay grades E–5 and above, $0; and

(iii) for retirees and their dependents, $230 individual, $460 family.

(d) *Outpatient cost sharing requirements under the uniform HMO benefit.*

(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special reduced cost sharing percentages or per service specific dollar amounts are required. The specific requirements shall be uniform and shall be published annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of outpatient cost sharing.* The special cost sharing requirements for outpatient services include the following specific structural provisions:

(i) For most physician office visits and other routine services, there is a per visit fee for each of the following groups: dependents of active duty members in pay grade E–1 through E–4; dependents of active duty members in pay grades of E–5 and above; and retirees and their dependents. This fee applies to primary care and specialty care visits, except as provided elsewhere in this paragraph (d)(2) of this section. It also applies to ancillary services (unless provided as part of an office visit for which a copayment is collected), family health services, home health care visits, eye examinations, and immunizations.

(ii) There is a copayment for outpatient mental health visits. It is a per visit fee for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents for individual visits. For group visits, there is a lower per visit fee for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(iii) There is a cost share of durable medical equipment, prosthetic devices, and other authorized supplies for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(iv) For emergency room services, there is a per visit fee for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(v) For ambulatory surgery services, there is a per service fee for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(vi) There is a copayment for prescription drugs per prescription, including medical supplies necessary for administration, for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(vii) There is a copayment for ambulance services for dependents of active duty members in pay grades E–1 through E–4; for dependents of active duty members in pay grades of E–5 and above; and for retirees and their dependents.

(3) *Amount of outpatient cost sharing requirements.* Beginning in fiscal year 1996, the outpatient cost sharing requirements are as follows:

(i) For most physician office visits and other routine services, as described in paragraph (d)(2)(i) of this section, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, $6;

(B) For dependents of active duty members in pay grades of E–5 and above, $12; and

(C) For retirees and their dependents, $12.

(ii) For outpatient mental health visits, the per visit fee is as follows:

(A) For individual outpatient mental health visits:

(*1*) For dependents of active duty members in pay grades E–1 through E–4, $10;

(*2*) For dependents of active duty members in pay grades of E–5 and above, $20; and

(*3*) For retirees and their dependents, $25.

(B) For group outpatient mental health visits, there is a lower per visit fee, as follows:

(*1*) For dependents of active duty members in pay grades E–1 through E–4, $6;

(*2*) For dependents of active duty members in pay grades of E–5 and above, $12; and

(*3*) For retirees and their dependents, $17.

(iii) The cost share for durable medical equipment, prosthetic devices, and other authorized supplies is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, 10 percent of the negotiated fee;

(B) For dependents of active duty members in pay grades of E–5 and above, 15 percent of the negotiated fee; and

(C) For retirees and their dependents, 20 percent of the negotiated fee.

(iv) For emergency room services, the per visit fee is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, $10;

(B) For dependents of active duty members in pay grades of E–5 and above, $30; and

(C) For retirees and their dependents, $30.

(v) For primary surgeon services in ambulatory surgery, the per service fee is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, $25;

(B) For dependents of active duty members in pay grades of E–5 and above, $25; and

(C) For retirees and their dependents, $25.

(vi) The copayment for each 30-day supply (or smaller quantity) of a prescription drug is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, $5;

(B) For dependents of active duty members in pay grades of E–5 and above, $5; and

(C) For retirees and their dependents, $9.

(vii) The copayment for ambulance services is as follows:

(A) For dependents of active duty members in pay grades E–1 through E–4, $10;

(B) For dependents of active duty members in pay grades of E–5 and above, $15; and

(C) For retirees and their dependents, $20.

(e) *Inpatient cost sharing requirements under the uniform HMO benefit.*

(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special cost sharing amounts are required. The specific requirements shall be uniform and shall be published as a notice annually by the Assistant Secretary of Defense (Health Affairs).

(2) *Structure of cost sharing.* For services other than mental illness or substance use treatment, there is a nominal copayment for active duty dependents and for retired members, dependents of retired members, and survivors. For inpatient mental health and substance use treatment, a separate per day charge is established.

(3) *Amount of inpatient cost sharing requirements.*

Beginning in fiscal year 1996, the inpatient cost sharing requirements are as follows:

(i) For acute care admissions and other non-mental health/substance use treatment admissions, the per diem charge is as follows, with a minimum charge of $25 per admission:

(A) For dependents of active duty members in pay grades E–1 through E–4, $11;

(B) For dependents of active duty members in pay grades of E–5 and above, $11; and

(C) For retirees and their dependents, $11.

(ii) For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge is as follows, with a minimum charge of $25 per admission:

(A) For dependents of active duty members in pay grades E–1 through E–4, $20;

(B) For dependents of active duty members in pay grades of E–5 and above, $20; and

(C) For retirees and their dependents, $40.

(f) *Limit on out-of-pocket costs for retired members, dependents of retired members, and survivors under the uniform HMO benefit.* Total out-of-pocket costs per family of retired members, dependents of retired members and survivors under the Uniform HMO Benefit may not exceed $3,000 during the one-year enrollment period. For this purpose, out-of-pocket costs means all payments required of beneficiaries under paragraphs (c), (d), and (e) of this section. In any case in which a family reaches this limit, all remaining payments that would have been required of the beneficiary under paragraphs (c), (d), and (e) of this section will be made by the program in which the Uniform HMO Benefit is in effect.

(g) *Updates.* The enrollment fees for fiscal year 1996 set under paragraph (c) of this section and the per service specific dollar amounts for fiscal year 1996 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged. The Secretary shall ensure that the TRICARE program complies with statutory cost neutrality requirements.

Dated: September 28, 1995.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Parts 110 and 165

[CGD 05–95–066]

Anchorage Grounds; Delaware River, Marcus Hook Range Channel, Marcus Hook Anchorage (Anchorage 7), Mantua Creek Anchorage (Anchorage 9), and Deepwater Point Anchorage (Anchorage 6). Safety Zone; Delaware River, Marcus Hook Range Channel

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone around dredging operations in the Marcus Hook Range channel adjacent to anchorage 7. To facilitate the rerouting of ship traffic through the area, the Coast Guard is suspending a regulation that allows ships to anchor for up to 48 hours in the Marcus Hook Anchorage (Anchorage 7), Mantua Creek Anchorage (Anchorage 9), and Deepwater Point Anchorage (Anchorage 6), and instituting temporary regulations governing these anchorages. The safety zone is needed to protect vessels, the port community and the environment from the hazards associated with dredging operations in the Marcus Hook Range channel and to minimize temporary port congestion during dredging operations. Entry into this zone is prohibited unless authorized by the Captain of the Port, Philadelphia, PA.

EFFECTIVE DATES: This rule is effective from 12:01 p.m., on September 20, 1995 until 6 a.m., on October 31, 1995.

FOR FURTHER INFORMATION CONTACT: LTJG S.J. Kelly, Project Officer c/o U.S. Coast Guard Captain of the Port, 1 Washington Ave., Philadelphia, PA. 19147–4395, Phone: (215) 271–4909.

SUPPLEMENTARY INFORMATION: In accordance with 5 U.S.C. 553, a Notice of Proposed Rule Making (NPRM) was not published for this regulation and good cause exists for making it effective in less than 30 days after Federal Register publication. The Coast Guard was informed by U.S. Army Corps of Engineers, Philadelphia District on August 30, 1995 that dredging